BUILDING TRADES
WELFARE BENEFIT FUND

SUMMARY PLAN DESCRIPTION

— PLAN E —

January 1, 2023

BUILDING TRADES WELFARE BENEFIT FUND
585 Stewart Avenue, Suite 330
Garden City, NY 11530
(516) 833-9300
Fax: (516) 833-9350

Issued January 2023

Dear Participant:

We are pleased to present you with this Summary Plan Description ("SPD") describing the benefits provided by the Fund for Program E. The Fund will inform you of any changes to your benefits as required by law. We suggest you review this material carefully in order to take full advantage of the benefits provided.

Benefits are provided to all eligible Employees of Contributing Employers that have been accepted to participate in the Fund and on whose behalf the Contributing Employer is making contributions to the Fund. Your Contributing Employer is required to make contributions to the Fund in a specified amount. Participants and Dependents may receive, upon written request to the Fund Office, information as to whether a particular employer is a Contributing Employer and if so, that Employer's address.

The Fund is administered by a Board of Trustees. The Board of Trustees has the power to interpret the provisions of this document and the terms used therein. Any such interpretation adopted by the Trustees in good faith will be binding upon you and your eligible Dependents.

Should you require any information or explanation, or need assistance in filing a claim for benefits, please feel free to contact the Fund Office at 585 Stewart Ave. Suite 330, Garden City, NY 11530: Telephone (516) 833-9300. You may also obtain further information about the Fund or contact the Fund Office through the Fund's website: www.btwelfarefund.org

Sincerely,

The Board of Trustees

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GENERAL INTRODUCTION

This document is both the Plan Document, and the Summary Plan Description, of Program E of the Building Trades Welfare Benefit Fund, for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The terms contained herein constitute the terms of the Plan. It is subject to administrative modification and interpretation by the Board of Trustees, and to the rules, regulations and procedures of the Plan in effect at the time your claim is made. The Board of Trustees has the right to interpret the terms of this document in situations not expressly addressed in this document. Capitalized terms are defined in the "Definitions" section of this SPD, beginning on page 20.

You should note, however, that the Trustees, in their sole and exclusive discretion, may, from time to time, change, amend, modify, discontinue and/or terminate in whole or in part, the benefits described in this Plan. If any benefit changes occur, the Fund Office will notify all Participants in accordance with applicable law.

The Fund has contracted with the insurance companies identified on page 58 to provide life insurance, AD&D, and short-term disability benefits. If you need additional copies of the booklets prepared by the insurance companies that describe the insured benefits available to you, you may request copies from the Fund Office. Taken together, all of these documents describe the benefits under the Fund and constitute the Summary Plan Description and Plan Document for Program E of the Building Trades Welfare Benefit Plan. The insurance companies have the discretion to make determinations about benefits provided under the insurance contracts. The Trustees have the right to change insurance companies or to change the contracts to reduce or eliminate the benefits provided to you and your Dependents. If you have trouble understanding any part of this material, contact the Fund Office. The address is 585 Stewart Ave. Suite 330, Garden City, NY 11530. Telephone: (516) 833-9300. The Fund Office hours are Monday – Friday, 9:00 A.M. to 5:00 P.M.

This document explains the benefits available to you under the Plan. **However, it is absolutely necessary that you verify coverage with the Fund Office before seeking care so that you can be sure that there is coverage under the Plan for you or your Dependents.**

Please remember that no one other than the Fund Office can verify your coverage. Do not rely upon any statement regarding coverage or benefits by the Fund made by your Employer, or anyone else other than the Fund Office staff.

It is extremely important that you keep the Fund Office informed of any change in address, desired changes in beneficiary or information regarding your Dependents. This is your obligation and you could lose benefits if you fail to do so. The importance of maintaining a current, correct address, email address and other information (including Social Security numbers) regarding you and your Dependents with the Fund Office cannot be overstated. It is the ONLY way the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

PRE-CERTIFICATION/MANAGED CARE AND SECOND SURGICAL OPINION

In the event you or your eligible Dependent requires Hospital confinement or surgery, you must call American Health Holdings, Inc. ("American Health"), 1-866-457-9882 prior to the surgery or Hospital confinement, and tell the pre-certification operator that you participate in the Building Trades Welfare Benefit Fund. The phone call is absolutely free.

WHEN SHOULD YOU CALL?

For **Planned Hospital Confinement**, please call at least fourteen (14) days prior to admission. If you are going to be admitted sooner than fourteen days, call the toll-free number as soon as you know what day you will be Hospital confined.

For **Maternity Cases**, please call within the first three (3) months of conception, or as soon as possible after confirmation of pregnancy, and again when you are hospitalized.

For **In-patient or Out-patient Surgery**, please call at least fourteen (14) days prior to planned surgery when recommended by your doctor. You may be required to obtain a second surgical opinion for surgical procedures listed below:

- Adeniodectomy
- Angioplasty
- Arthroplasty
- Breast Surgery
- Carpal Tunnel
- Cataract Removal
- Cholecystectomy
- Colectomy
- Coronary Bypass
- D & C
- Exploratory Laparotomy
- Foot Surgery
- Gastric Bypass
- Heart Catheterization
- Hemorrhoidectomy
- Herniorrhaphy
- Hysterectomy
- Insertion of Pacemaker
- Knee Surgery
- Nasal Surgery
- Prostate Surgery
- Spinal Surgery
- Tonsillectomy
- Varicose Veins

All Gene Therapy treatment is required to be pre-certified.

WHAT INFORMATION SHOULD BE REPORTED?

When calling 1-866-457-9882 for pre-certification or for a second surgical opinion, please give the name, address, social security number, and age of the patient, the Participant's social security number (if the Participant is not the patient), name of employer, date of planned admission or surgical procedure. You should also give your doctor's name, address and telephone number.

WHAT HAPPENS IF YOU DON'T CALL?

If you do not call American Health when pre-certification is required, you may incur a penalty. If you fail to pre-certify and your treatment is determined to be Medically Necessary, you may incur a $200 penalty. If you fail to pre-certify and your treatment is determined not to be Medically Necessary, coverage for your treatment may be denied and you may be required to pay the entire bill yourself. There is no cost to you for making the call. All information given will be completely confidential. Notwithstanding anything in this Section to the contrary, no prior authorization is required for Emergency Services.

The Board of Trustees is always concerned with the ever-increasing costs of providing healthcare services, and we all have a role to play in seeing that medical care remains affordable. You, as a claimant, must be sure that your benefit payments are for care and treatment that is necessary and at a reasonable charge. You will help this effort greatly by complying with the pre-certification requirements and calling American Health prior to treatment.

ACCESSING THE PROVIDER NETWORK

The Fund has arranged for you to have access to a network of Physicians, surgeons, chiropractors, labs and X-ray facilities in the Greater New York area. These benefits as well as discounted Hospital bills, are provided through a contract with Empire Blue Cross Blue Shield/Anthem ("BCBS"). You can determine whether a provider participates in the BCBS network through an online directory on the Fund's website -- www.btwelfarefund.org

In order to help you get the best possible results in utilizing this network, the Fund requires you to follow these simple guidelines:

1) Please call the Fund Office if you have any questions regarding what benefits are provided by the Fund and whether or not you are responsible for Co-payments or Coinsurance.

2) After selecting a BCBS Provider from the online directory or by calling 1-800-810- BLUE, simply call to make an appointment. Be sure to verify that the service provider you are calling is still a participating provider in the BCBS network.

3) If you need help in selecting a provider, you may call BCBS directly at 1-800-810-BLUE or by accessing the Internet at www.Anthem.com

4) When you arrive at the doctor's office, present your BCBS card or identify yourself as a BCBS Participant. Be prepared to give your social security number and identify yourself as a participant of the Building Trades Welfare Benefit Fund. Your Dependents should also use your social security number.

5) If your doctor requires lab work or X-rays, be sure to advise him that you would like the work to be done by a participating BCBS lab or facility. BCBS doctors know which labs and X-ray facilities are in the BCBS network.

6) If you or your Dependents require hospitalization, be sure to advise your doctor that you would like to be admitted to a Hospital that participates in the BCBS network.

7) If you receive a bill from a provider, do not ignore it. Complete the information section of the bill using your social security number and the Building Trades Welfare Fund group information. Send the bill to the Fund Office at 585 Stewart Ave. Suite 330, Garden City, NY 11530.

8) All Plan maximums and limitations found in this Summary Plan Description booklet will apply.

With your BCBS identification cards, you may go to any medical doctor that is a BCBS Provider. You will not be required to pay any amounts out of pocket when you see a BCBS Provider. You are not required to use a primary care Physician. A directory of providers is available online through the Fund's website www.btwelfarefund.org or by calling 1-800-810-BLUE.

Remember, it is your responsibility to make sure that each provider/facility you use is a BCBS Provider. If you have any questions as to whether or not a provider is part of the BCBS network, please call the BCBS Customer Service Department at 1- 800-676-BLUE.

You may choose to use a Non-Participating Provider. If this is the case, you will need to complete a claim form and have the claim processed as explained in the claims information section, beginning on page 78 of this document. Please be advised that you may be responsible to pay more for your services if you use a Non-Participating Provider.

It is important that you keep the Fund Office advised of any change in your address or family status. Your failure to do so could affect your benefit status.

Continuing Care Patients

If a BCBS Provider leaves the network, you may continue to receive treatment from that provider for a limited period of time as if the provider remained in the in-network, provided you are considered a "Continuing Care Patient" and you timely make an election to be so treated. A Continuing Care Patient means an individual who is: (1) receiving a course of treatment for a Serious and Complex Condition; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility. To be treated as a Continuing Care Patient, you must properly complete an election form and return it to the Fund Office within 30 days of the date on which it is provided to you. Once the Fund Office receives a properly completed election form, it will determine whether you meet the requirements for Continuation of Care. If you are considered a Continuing Care Patient and timely make an election, services rendered by that provider will be treated as "in-network" until the earlier of: (i) the 90th day after the provider left the network or you were provided with a Continuation of Care notice and election form, whichever is later; or (ii) the date on which you no longer need treatment for the condition that made you a Continuing of Care Patient.

HOW THE PLAN WORKS

Overview

Unless subject to an exclusion or limitation in this booklet, for Covered Services rendered by a BCBS Provider, you are generally not required to pay anything out of pocket. There are no co-payment requirements for services with a BCBS Provider. However, Covered Services rendered by a Non-Participating Provider are provided in three parts: Basic Plan benefits, Major Medical benefits, and other benefits provided by the Fund through contracts with service providers.

For Services Rendered by Non-Participating Providers only

A. *The Basic Plan Benefits*

The Basic Plan provides coverage for certain services, generally at a greater percentage than the Major Medical Benefits, subject to the limits specified in the Basic Plan Schedule of Benefits. There is no Deductible or co-payment required for Basic Benefits, but there may be a Coinsurance.

B. *Major Medical Benefits*

Major Medical is additional coverage on top of Basic Plan benefits. It is designed to pay benefits for Out-of-Network Covered Services that exceed the Basic Plan Benefits. For this additional coverage a Deductible must be satisfied before Covered Expenses are paid, unless the Expenses are for Child Wellness or routine mammography charges, for which no Deductible applies. In some cases, as described in the Major Medical Schedule of Benefits, you may also be responsible for paying a portion of the charges, referred to as Coinsurance. In addition, for services other than Surprise Services, you are responsible to pay any amounts billed by the Non-Participating Provider that exceed the Maximum Allowable Amount.

When you submit a claim:

1. The Basic Plan will first be used to pay for Covered Services, up to the allowable maximums specified in the Basic Plan Schedule of Benefits.

2. Covered Expenses in excess of the Basic Plan benefits will then be applied toward the annual Major Medical Deductible. This Deductible must be satisfied before you or your Dependents are entitled to Major Medical benefits, unless prohibited by applicable federal law.

3. Once the Deductible has been satisfied, Major Medical benefits begin according to the Major Medical Schedule of Benefits.

C. *Other Plan Benefits*

Vision Care
Hearing Aids
Prescription Drug Benefits
Dental Benefits
Home Health Care
Life Insurance and AD&D Benefits

BASIC PLAN SCHEDULE OF BENEFITS

Except with respect to hearing aids, dental and vision care for Covered Persons, the coverage limits described in this Schedule are intended to describe when Basic Plan Benefits end and Major Medical Benefits commence.

Basic Plan Benefits for Participants and Dependents

Hospital Expense Benefit

Maximum Daily Hospital Room and Board Benefit:

For Ward and Semi-Private Accommodations: 100% of the Maximum Allowable Amount for the first 120 days and 50% of Maximum Allowable Amount for the next 180 days

For Private Accommodations and Intensive Care Unit: 100% of the Maximum Allowable Amount for the first 120 days of the Semi-Private Accommodations and 50% of Maximum Allowable Amount for the next 180 days

Maximum Period Payable: 300 days per calendar year

Home Health Care Expense Benefit

The Plan pays 75% of Maximum Allowable Amount, up to a maximum of 40 visits in any 12-month period.

Skilled Nursing Facility Expense Benefit

80% of the Maximum Allowable Amount for a maximum of 30 days. This 30-day maximum is combined with the Hospital benefit and In-Patient Rehabilitation.

Surgical Expense Benefit

100% up to the amount listed in the Schedule of Operations.
Additional Surgical Opinion: $150.00 maximum

Medical Expense Benefit

Benefits Begin: on the first day for office visits or a Hospital visit
100% of billed charges up to $40 per visit and subject to a maximum of $1,250 per year.

Medical Consultation Benefit

100% of billed charges up to $50

Annual Physical Examination Benefit
(includes weight, blood work, electrocardiogram, chest x-ray, blood pressure and mandatory mammography)

The Plan pays 100% of the Maximum Allowable Amount
Maximum Benefit per calendar Year: 1 visit

X-Ray and Diagnostic Expense Benefit

100% of billed charges up to $750.00

X-Ray and Radioactive Therapy Expense Benefit

100% of billed charges up to $500.00

Supplementary Expense Benefit

Maximum Benefit per Any One Injury: $1,250.00 (Ambulance service limited to 2 calls for each separate Injury or Sickness)

Vision Care Expense Benefit

Maximum Benefit per Examination and Prescribed Glasses: $350.00

If the service is provided by a participating optometrist or optician, the full cost will be covered for the eye examination and for one pair of lenses and basic frames. Contact the Fund Office for a current list of participating optometrists and opticians. If the service is not provided by a participating optometrist, then up to $350.00 will be paid towards the cost of the eye examination and for a pair of lenses and basic frames.

Prescription Drug Benefit

Prescription Drug Benefits are provided through Maxor Plus and are subject to the limitations described in this SPD.

Mental, Nervous and Emotional Disorder and Ailment Benefit

Maximum Daily In-patient Benefit:

For Ward and Semi-Private Accommodations: 100% of the Maximum Allowable Amount for the first 120 days and 50% of Maximum Allowable Amount for the next 180 days

For Private Accommodations and Intensive Care Unit: 100% of the Maximum Allowable Amount for the first 120 days of the Semi-Private Accommodations and 50% of Maximum Allowable Amount for the next 180 days.

Alcohol and Substance Abuse Expenses

For Ward and Semi-Private Accommodations: 100% of the Maximum Allowable Amount for the first 120 days and 50% of Maximum Allowable Amount for the next 180 days.

For Private Accommodations and Intensive Care Unit: 100% of the Maximum Allowable Amount for the first 120 days of the Semi-Private Accommodations and 50% of Maximum Allowable Amount for the next 180 days.

Major Medical Schedule of Benefits

Deductible Amount per Calendar Year

No deductible for BCBS Providers.

$100.00 per Covered Person, or $250.00 per family per calendar year for services rendered by Non-Participating Providers.

One family will not be required to meet a Deductible amount greater than $250.00. If that amount is reached, no further Deductible amount will be required from Covered Persons in the family for the rest of the calendar year.

If two or more Covered Persons in a family are injured in the same accident, only one Deductible amount will be needed. The single Deductible will apply to all Covered Expenses incurred by them as a result of the accident during that year and the next calendar year.

Covered Expenses incurred in the last 3 months of a Calendar Year, which are applied against the Deductible amount in that year, will also be used to reduce the Deductible for the next Calendar Year.

The Deductible amount applies to all Covered Expenses, except the following:

1. For Child Wellness Charges;
2. Charges for routine mammography;
3. Annual Physical Exam
4. Any other services for which a Deductible cannot be applied by applicable federal law.

Once the Deductible is satisfied, the Fund will pay a percentage of the Maximum Allowable Amount, as described in this SPD. You are responsible for any amounts billed by your Non-Participating Provider that are not covered by the Fund, except for Surprise Services that are Covered Services, for which you will have no out-of-pocket obligation, even if the provider charges more than the Maximum Allowable Amount. You are encouraged to use a BCBS Provider whenever possible—because, in general, it will result in you paying less out-of-pocket.

Out-of-Pocket Expenses

After $5,000.00 in Coinsurance for Covered Expenses has been paid by a Covered Person during any one calendar year, then 100% of the Maximum Allowable Amount for Covered Expenses will be paid during the remainder of that calendar year. You are still responsible for any amounts billed by the Non-Participating Provider in excess of the Maximum Allowable Amount, to the extent permitted by applicable law.

Mental and Nervous Disorders

Same as any Sickness.

Alcohol and Drug Abuse

Same as any Sickness.

Dental Expense Benefit

Maximum:

Per Schedule of Benefits with participating dental panel. If a Covered Person uses a provider that is not a member of the participating dental panel then the Dental Expense Benefit will be paid up to the amount that would be paid to a provider that is a member of the participating dental panel.

Orthodontic Service: $5,000.00 Lifetime Maximum
The lifetime and quarterly maximums do not apply to certain orthodontic services that are considered essential health benefits under federal law using the New York State benchmark plan.

Short Term Disability Benefit

Maximum Benefit per Week:

50% of your weekly earnings up to a maximum benefit of $170 per week
Maximum Period Payable: 26 weeks

Life and Accidental Death & Dismemberment Insurance

Life Insurance (Active Employee Only)..$40,000.00
Life Insurance (Active Employee's Lawful Spouse Only).................................$10,000.00
Life Insurance (Retiree Only)* $10,000.00
Accidental Death & Dismemberment Principal Sum (Active Employee Only) $40,000.00

*To be eligible for the Life Insurance (Retiree Only) benefit, you must also be receiving a pension from the Electrician's Retirement Fund.

GENERAL INFORMATION

WHO IS ELIGIBLE?

All Employees: (1) who are eligible to participate in this Program pursuant to the underlying collective bargaining agreement or participation agreement; (2) on whose behalf contributions are properly made to the Fund; and (3) who meet the eligibility requirements described in this Section, are eligible for benefits.

If you are an active Employee who has reached age 60, you and your Spouse may be eligible for retiree health benefits if you completed at least 25 years of consecutive service with a Contributing Employer that contributed to the Fund or the former Local 363 Welfare Fund "E", you work in Covered Employment until the day you retire under the Electrician's Retirement Fund and at the time of your retirement, you are participating in Program E. Your Dependent spouse may also be eligible for coverage, provided that you agree to pay the required monthly premiums for your Spouse.

WHEN AM I ELIGIBLE?

An Employee eligible to participate in this Program E becomes a Participant on the first day of the month after the month in which the Employer first makes a contribution to the Fund on the Employees behalf. For example, assume you are hired by ABC Electric on August 7, 2024 as an electrician. Under the terms of the collective bargaining agreement governing your employment, ABC Electric is required to contribute to the Fund's Program E for all electricians beginning with the month in which they are hired. Provided ABC Electric makes a contribution on your behalf in August 2024, your coverage under this Program E will start September 1, 2024.

Retiree Coverage

If you are an active Employee who has reached age 60, you have completed at least 25 years of consecutive service with a Contributing Employer that contributed to the Fund or the former Local 363 Welfare Fund "E" on your behalf, you work in Covered Employment until the day you retire under the Electrician's Retirement Fund and at the time of your retirement, you are covered under this Program E, you and your spouse will be eligible for retiree health benefits. You will be eligible for benefits until you become eligible for Medicare, or you reach age 65. If you elect retiree coverage for your Spouse, your Spouse will remain eligible for retiree benefits for up to a maximum of 24 months past the date that your eligibility ends either because your coverage was terminated or because of your death, provided that in no event will your Spouse's coverage continue beyond (1) your spouse's 65th birthday, (2) the date your Spouse becomes eligible for Medicare, or (3) the date required monthly premiums are not timely received.

If you work in Covered Employment until the attainment of age 65 (or later), were covered under this Program E at the time of you retirement, have completed at least 25 years of consecutive service with a Contributing Employer that contributed to the Fund or the former Local 363 Welfare Fund "E" on your behalf and are married at the time of your retirement, your Spouse is eligible for retiree benefits for up to a maximum of 24 months from the date on which you terminated Covered Employment, provided that in no event will your Spouse's coverage continue beyond (1) your

Spouse's 65th birthday, (2) the date your Spouse becomes eligible for Medicare, or (3) the date required monthly premiums are not timely received.

If you are an active Employee between ages 60 and 65, you have completed at least 25 years of consecutive service with a Contributing Employer that contributed to the Fund or the former Local 363 Welfare Fund "E" on your behalf, you work in Covered Employment until the day you die and you were covered under this Program E at the time of your death, your Spouse will be eligible for up to 24 months of retiree health benefits from the date of your death, provided that in no event will your Spouse's coverage continue beyond (1) your Spouse's 65th birthday, (2) the date your Spouse becomes eligible for Medicare, or (3) the date required monthly premiums are not timely received.

You must submit an application for retiree coverage and if approved, monthly premiums must be paid to the Fund in order to maintain coverage for you and your Spouse. Please contact the Fund Office for information regarding the premiums for coverage for you and your Spouse.

You can elect to have the premiums deducted from your monthly pension benefits with the Electrician's Retirement Fund, by contacting the Fund Office and completing the required authorization form. Alternatively, you can pay by check or money order made payable to Building Trades Welfare Benefit Fund. After initial enrollment, required monthly contributions must be received by the Fund Office by the 10th day of the month for which coverage is to be provided. Required monthly contributions must be made consecutively. If you fail to timely make a monthly payment, coverage for you and your Spouse (if applicable) will terminate and you cannot get it back.

The amount of required monthly contributions will be determined by the Trustees in their sole discretion, and the amounts may be changed from time to time, to cover increased costs of providing benefits.

UNDER WHAT CIRCUMSTANCES MIGHT I BECOME INELIGIBLE OR RISK DENIAL, FORFEITURE, SUSPENSION, OR REDUCTION OF BENEFITS?

Current Employees

You will remain eligible for coverage under Program E for each month during which you continue to work in Covered Employment that requires contributions to be made to the Fund's Program E and provided that such contributions are timely received.

Retirees

Coverage for retiree benefits will continue consistent with rules described on pages 10-11. However, the Trustees reserve the right to discontinue retiree coverage at any time. If the Trustees decide to discontinue retiree coverage, coverage for you and your Spouse will end on the date determined by the Trustees.

ARE MY DEPENDENTS ELIGIBLE?

For purposes of the retiree health benefits offered by the Fund, only your legal Spouse of the opposite sex will be considered your Dependent. No retiree health benefits are available to other Dependents, as that term is defined on page 21.

For active coverage, your eligible Dependents are:

(a) your legal spouse of the opposite sex; and

(b) each eligible child as described beginning on page 21,

provided your Dependent(s) are listed on the Fund Enrollment Card on file with the Fund Office. In the event that both parents are Participants in the Fund, then the child will be considered a Dependent of one of the parents, but not both. If two spouses are participants in the Fund, but only one participates in Program E, the individual that participates in Program E will be considered the Participant and all eligible Dependents will participate in this Plan E.

An eligible Dependent who is not listed on a Fund Enrollment Card will be enrolled in coverage if required by a Qualified Medical Child Support Order ("QMCSO"). The Fund will provide coverage to a child under a QMCSO to the extent required by law. If the Fund receives a QMSCO and if the Participant does not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained free of charge from the Fund Office.

The Fund also will provide Dependent coverage for a child that is placed for adoption with a Participant regardless of whether the adoption is finalized. A child will be considered placed for adoption with a Participant if the Participant assumes a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. The child's placement with the Participant will be considered terminated when the Participant's obligation to support the child has terminated. A Participant will be required to supply evidence to the Fund that a child for whom Dependent coverage is requested has actually been placed with the Participant for adoption.

WHEN ARE MY DEPENDENTS ELIGIBLE?

Your Dependent who is listed on the Fund Enrollment Card on file with the Fund is eligible for benefits on the same day that you become eligible. If you are eligible for benefits, then your newborn Dependent child is immediately eligible for coverage at birth for Injury, Sickness, premature birth, or congenital disease or anomaly, provided you properly enroll the newborn child by providing the Fund Office a copy of the child's Social Security Number and birth certificate within thirty (30) days of birth. If you and/or your Dependents decline coverage under this Plan because you and/or your Dependents are covered under either the State Children's Health Insurance Program ("CHIP") or under Medicaid and you lose eligibility for this coverage or you become eligible for financial assistance under either of these programs, you and your Dependents may be able to enroll in Fund coverage so long as you and your Dependents satisfy all the eligibility requirements described in this SPD. If you notify the Fund within 60 days of losing coverage under CHIP or Medicaid or becoming eligible for financial assistance, coverage will be effective retroactive to the date CHIP or Medicaid coverage terminated or financial assistance was granted.

Otherwise, coverage is effective on the date notice is received by the Fund.

If you are eligible for retiree health benefits, your Dependent spouse will also be eligible, provided you pay the required monthly premiums for your spouse.

HOW DO I ENROLL IN THE PLAN?

You must fully complete a Fund Enrollment Card. This card must include the names, addresses, email addresses, sex, social security numbers, and dates of birth for you and all Dependents you wish to have covered. The Fund cannot process your claim for benefits if it does not have a properly completed card. Enrollment cards may be obtained by calling or writing to the Fund Office. You may add or remove Dependent(s) by completing a new Fund Enrollment Card. The eligibility of added Dependent(s) is determined under the provisions described above.

HOW DO I HANDLE A CHANGE IN FAMILY STATUS?

If a change occurs in your family status by reason of marriage, birth of a child, adoption of a child or the placement for adoption of a child, death, divorce, or legal separation, you must notify the Fund Office immediately. Under any of these circumstances, a new Fund Enrollment Card must be completed.

WHEN DO BENEFITS TERMINATE?

Your benefits, and those of your eligible Dependents, will terminate on the last day of the month during your last month of work in Covered Employment. However, if you terminate Covered Employment because of Total Disability or maternity, your eligibility for benefits, and those of your Dependents, will continue for six (6) months from the last day of the month in which your Total Disability or maternity occurred. Thereafter, (after the initial 6 months) benefits will continue for an additional 6 months but only for claims relating to the disability that caused the initial cessation of employment. In addition, if your employer does not timely make a required payment to the Fund on your behalf, your coverage will terminate consistent with the rules of the Fund's Policy for the Collection of Delinquent Contributions, except that prescription drug coverage may continue for up to 6 months from the date your employer made its last contribution to the Fund on your behalf. Notwithstanding the foregoing, if you begin working in the types of employment covered by the Fund for a non-contributing employer, all coverage will end on the date you begin working for such non-contributing employer.

Benefits for your Dependent also will terminate on the date when that individual ceases to be a Dependent or on the effective date that dependent coverage is eliminated under this Program, if earlier. All benefits terminate immediately if the Plan is terminated or if your Employer ceases to be a Contributing Employer to the Fund.

The Trustees expressly reserve the right, in their sole discretion, and at any time, to amend or terminate the retiree benefits provided under the Plan. In the event the Trustees terminate retiree benefits, your retiree coverage will end on the date the Fund discontinues such coverage.

IF MY BENEFITS END, CAN I CONTINUE BENEFITS BY PAYING FOR THEM MYSELF?

Yes, under certain conditions, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for you and your Dependents to continue health coverage for specified periods of time after your coverage is terminated. This booklet contains a section describing COBRA continuation coverage beginning on page 58. Coverage may also be available while you are in military service, as described below.

CONVERSION

In certain circumstances, when your coverage for the Life and Accidental Death and Dismemberment benefits terminates, you may continue these benefits through an individual policy. Please refer to the booklets from the insurance providers for more details.

HOW DOES MILITARY SERVICE AFFECT MY ELIGIBILITY FOR BENEFITS?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires that the Fund provide the right to elect continued health coverage for up to 24 months to Participants who are absent from Covered Employment due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

A Participant who is absent from employment by reason of service in the uniformed services can elect to continue coverage for the Participant and his or her eligible Dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which the Participant's absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which the Participant is required to, but fails to, apply under USERRA for or return to a position of employment covered under the Fund. (For example, for periods of service over 180 days, generally the Participant must reapply for employment within 90 days of discharge.)

This right to temporarily continue group health coverage does not include any life insurance benefits, accidental death and dismemberment benefits, accident and sickness benefits or other similar non-health benefits provided by the Fund. In addition to the right to continued coverage under USERRA, Participants or Dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Please refer to the COBRA Section of your SPD for more information.

If the Participant met the Plan's eligibility requirements at the time he or she entered the uniformed

services, the Participant will not be subject to any additional exclusions or a waiting period for coverage under the Fund upon return from uniformed service, to the extent required by USERRA.

Notice and Election of USERRA Coverage

The Participant must notify his or her Employer or the Fund Office of the absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If the Participant wishes to elect USERRA coverage, he or she also must notify the Fund Office within 60 days of the last day of employment unless the Participant is excused from giving advance notice of service under the provisions of USERRA. While an Employee may notify an employer of service orally, the Fund requires that Participants elect USERRA coverage in writing. The Fund will provide you with the necessary forms.

Paying for USERRA Coverage

The Participant may be required to pay all or a portion of the cost of coverage during USERRA leave. If the period of military service is less than 31 days, there is no charge for this coverage beyond the normal Deductible or Coinsurance that would be paid if the Participant were employed. If the military service extends more than 31 days, the Participant must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage is sought. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to timely make all required payments. The Fund will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to untimely payment.

WHAT HAPPENS TO MY COVERAGE IF I TAKE FMLA LEAVE?

The Family and Medical Leave Act of 1993 ("FMLA") generally requires that an employer with 50 or more Employees provide Participants with up to twelve (12) weeks per year of unpaid leave in the case of the birth or adoption of your child and for your own illness or to care for a seriously ill child, spouse or parent. You may also be entitled to FMLA leave for a qualifying exigency that

arises in connection with the active military service of your child, spouse, or parent. A qualifying exigency includes (a) notification of military deployment within 7 days of the deployment date; (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; (d) making financial and legal arrangements; (e) attending counseling sessions; (f) up to 5 days of rest and recuperation; (g) attendance at post-deployment activities.

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service. Contact the Fund Office for more information.

In compliance with the provisions of the FMLA, your Contributing Employer may be required to maintain your coverage under the Plan during the period of your leave under the FMLA. If you are entitled to coverage under the Plan during a period of time under the FMLA, your coverage as a Participant on FMLA leave will cease once the Fund is notified or otherwise determines that you have terminated employment, exhausted your FMLA leave entitlement or you inform the Fund of your intent not to return from leave. Once the Fund is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect Continuation Coverage under COBRA, as described under the COBRA section of this booklet. The event entitling you to coverage under COBRA occurs on the last date of FMLA leave. The Fund cannot condition your entitlement to coverage under COBRA on your reimbursing the Contributing Employer for premiums associated with the cost of coverage during the FMLA leave period, as discussed below.

If you return to Covered Employment for 30 days, the Contributing Employer may not seek to recover the value of the benefits paid. However, if you fail to return to active employment with a Contributing Employer following a period of FMLA leave, the Contributing Employer may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave. If you fail to return from FMLA leave because of the continuance, recurrence or onset of a serious health condition that affects you, your spouse, child or parent, and such health condition would have entitled you to FMLA leave, then the Contributing Employer will not seek to recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave.

WHAT HAPPENS IF MY SPOUSE ALSO HAS HEALTH COVERAGE?

Members of a family are often covered by more than one Health Plan. As a result, two or more plans may pay for the same Covered Service. To avoid this costly problem, this Plan provides a Coordination of Benefits provision. This provision affects you and all of your Dependent(s). It does not apply to Life or Accidental Death and Dismemberment coverage. This provision will apply in determining the benefits for a person covered under this Plan for medical or dental Covered Expenses for any Claim Determination Period, if for the Covered Expenses incurred by that person during that period the sum of:

(1) the benefits that would be payable under this Plan in the absence of this provision; and

(2) the benefits that would be payable under all other Health Plans in the absence of provisions in those Health Plans of similar purpose to this provision would exceed the Covered Expense.

As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision will be reduced to the extent necessary, so that the sum of the reduced benefits and of all of the benefits payable under all other Health Plans (except as described below) will not exceed the total of the Covered Expenses. Benefits payable under other Health Plans include the benefits that would have been payable had a claim been made.

Which Plan Pays First?

The Health Plan under which benefits are payable first is referred to as the primary plan. All other plans are called secondary plans. The rules for determining which Health Plan has the primary responsibility for benefit payments are as follows:

(1) If one Health Plan does not contain a Coordination of Benefits provision, it will automatically be primary and pays first;

(2) If the claimant is covered as an Employee under one Health Plan and a Dependent under the other, then the Health Plan under which the claimant is covered as an Employee is primary and pays first;

(3) If the individual is covered as an Employee under two Health Plans, the plan which has covered him the longest is primary and pays first.

(4) If the individual is covered under this Plan after the termination of employment with a Contributing Employer to complete the remainder of the Coverage Period or under any other coverage extension rules, and another Health Plan, the other Health Plan is primary.

The rules below determine which plan's benefits are payable first if a Dependent child is covered under two or more Health Plans:

(1) *If the parents are not divorced or legally separated:*

If the claimant is a Dependent child under both Health Plans, the Health Plan covering the parent whose birth date falls earlier in the calendar year is primary and pays first. If the birthday of both parents occurs on the same date, the plan which has covered the parent for the longer period of time pays first. However, if the Health Plan with which this Plan is coordinating benefits bases its coordination on sex, then the rule in the other plan will determine the order of payment, except if the parents are divorced or legally separated.

(2) *If the parents are divorced or legally separated the following rules will apply:*

(A) When a court decree has established which parent has financial responsibility for the child's health care Expenses, then that parent's Health Plan will be primary;

(B) When financial responsibility has not been legally determined, or such responsibility is equally divided, then the Health Plan that covers the child

of the parent with legal custody will be primary;

(C) If the parent with legal custody remarries, then the primary responsibility will lie with the Health Plan that covers the first applicable of the following:

(i) the natural parent with whom the child resides;

(ii) the step-parent with whom the child resides;

(iii) the natural parent not having custody of the child;

(iv) if a Participant or Dependent has Medicare as primary coverage, the benefits will be coordinated in accordance with federal law regarding Medicare coverage;

(v) if none of the above applies, then the Health Plan in which the claimant has been enrolled the longest will be primary.

DEFINITIONS

Ancillary Services means, with respect to services provided at an in-network BCBS Provider facility and except to the extent excluded by applicable law, Covered Services that are (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services; (4) items and services provided by a Non-Participating Provider if there is no BCBS Provider who can furnish such item or service at such facility; (5) other services defined as ancillary under the No Surprises Act and its implementing regulations.

BCBS Provider means a provider of medical or Hospital benefits, including a facility, that participates in the BCBS network.

Child Wellness Charge means a charge for a complete physical, including hearing, vision and routine laboratory exams for a child under the age of 19.

Claim Determination Period means a calendar year or that portion of a calendar year during which the Covered Person is covered under this Plan.

COBRA means the amendments made to ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1985, and regulations thereunder, as amended from time to time.

Code means the Internal Revenue Code of 1986, and regulations thereunder, as amended from time to time.

Coinsurance means that percentage of a Covered Expense that the claimant is required to pay to the provider for the services provided.

Contributing Employer or Employer means an employer that has signed a collective bargaining agreement or other written agreement requiring it to make contributions to the Fund or who is required by law to contribute to the Fund on behalf of its Employees.

Covered Employment means a job classification for which contributions are required to be made to the Fund pursuant to the terms of a collective bargaining agreement or other written agreement between and Employer and the Fund.

Covered Expense means any ***Medically Necessary*** expense for medical or dental care, at least a portion of which is covered under the Plan.

Covered Person means a Participant and his or her eligible Dependent(s).

Covered Service means a service, product or treatment that is covered under the terms of this document and is not subject to any limitations or exclusions.

Custodial Care means care that consists of services and supplies furnished primarily to help a person in the activities of daily living and that does not require the continuous attention of trained

medical/paramedical personnel. Such care may involve preparation of special diets, supervision over medication that may be self-administered, assistance in getting in or out of bed, walking, bathing, dressing, eating, and using the toilet. Such services are Custodial Care regardless of the practitioner or provider who prescribed, recommended or performed them.

Deductible means the Covered Person's out-of-pocket expense for Out-of-Network benefits that is required to be paid before the Major Medical benefits begin to be paid by the Fund.

Dentist means a duly licensed doctor of dentistry acting within the scope of his license who is not a member of the Covered Person's immediate family.

Dependent(s)

(a) **In General. Dependent(s)** means the legal spouse of the opposite sex ("Spouse") and each child under the age of 26 through the end of the month in which they turn age 26.

"Child" includes natural child, stepchild, adopted child, child placed with you for adoption, foster child and child for whom you have been duly appointed as the legal guardian. Dependent also includes someone who is provided coverage under this Plan pursuant to a Qualified Medical Child Support Order.

For purposes of the retiree health benefits available from the Fund, an eligible Participant's spouse may be considered a Dependent. No retiree health benefits are available to a child who may be a Dependent.

(b) **Dependents with Disabilities**. An unmarried child who has attained age 26 will continue to be an eligible Dependent, if:

(1) the child is handicapped and remains incapable of self-sustaining employment by reason of mental retardation or physical handicap;
(2) acceptable evidence of such incapability is furnished to the Fund with respect to any such child within 31 days after the later of: (a) the child attaining age 26, or (b) the Eligible Employee receiving notice of such handicap; and
(3) proof of such incapability is furnished to the Fund for time to time at the Fund's request.

If a claim for an extension of an eligible Dependent's coverage because of disability is denied based on a determination by the Fund that the Dependent is not disabled, the Fund will provide such notification in a denial letter or in an appeal denial letter with information regarding additional rights, as required by law for disability claims.

(c) **Multiple Coverage under the Plan.** In the event that both parents are Participants, then such child will be considered a Dependent of one of the parents, but not both.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and

medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Medical Services means the any of the following, with respect to an Emergency Medical Condition

- An appropriate medical screening examination that is within the capability of the emergency department of a Hospital, including Ancillary Services routinely available in the emergency department to evaluate the Emergency Medical Condition;
- Further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished);
- Post-stabilization services following an Emergency Medical Condition to the extent required by applicable law.

Employee means a person who is employed by a Contributing Employer that is required by a collective bargaining agreement or by other written agreement or law to make contributions to the Fund. Employee also means a retired individual that meets the eligibility requirements for retiree coverage.

ERISA means the Employee Retirement Income Security Act of 1974, and regulations thereunder, as amended from time to time.

Expense means a charge a Covered Person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Experimental means the use of treatment, procedures, facilities, equipment, drugs, medical or pharmaceutical agents, devices or supplies not yet generally recognized as accepted medical practice and any such services, facilities, equipment, drugs or supplies requiring federal or other government agency approval and for which such approval has not been granted at the time the services were rendered.

FMLA means the Family and Medical Leave Act of 1993, and regulations thereunder, as amended from time to time.

Fund means the Building Trades Welfare Benefit Fund established under the Fund's Trust Agreement, effective as may thereafter be amended or restated.

Gene Therapy means a Medically Necessary nonexperimental technique approved by the Food and Drug Administration that uses human genes to treat or prevent disease in humans that involves introducing human DNA, which contains a functioning gene to correct the effects of a disease-causing mutation, into an individual to replace or correct the effects of a disease-causing mutation. Non-human gene therapy does not constitute Gene Therapy.

Health Care Facility. For non-Emergency Services, means a: (1) Hospital; (2) Hospital outpatient department; (3) critical access hospital; or (4) ambulatory surgical center.

Health Plan means any plan providing benefits or services for medical/dental treatment, when such benefits or services are provided by (a) group insurance coverage, (b) an employer- sponsored Blue Cross, Blue Shield, or other prepayment coverage, (c) any coverage under labor- management trusteed plans or employee benefits organization plans, including this Plan, (d) any coverage under governmental programs, (e) any coverage required or provided by statute (except Medicaid), (f) any mandatory "no-fault" coverage. Health Plan does not include a state plan under Medicaid; benefits under a law or plan when its benefits by law are excess to any private insurance plan; individual or family coverage except as described above; Medicare with respect to an actively employed Covered Person or spouse; disabled Covered Person; or school accident coverage. Dental Expenses will be coordinated only with like coverage from another Plan.

The term ***Health Plan*** will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract, or other arrangement, which reserves the right to take the benefits and that portion which does not reserve such right.

Hospital means an establishment that meets all of the following requirements: (1) holds a license as a hospital (if licensing is required in the state); (2) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (3) provides twenty-four (24) hour- a-day nursing service by registered or graduate nurses on duty or call; (4) has a staff of one or more licensed Physicians available at all times; (5) provides organized facilities for diagnosis and surgery either on its premises or at an institution with which the establishment has a formal arrangement for the provision of such facilities; and (6) is not primarily a clinic, nursing, rest or convalescent home or an extended care facility or a similar establishment and is not (other than incidentally) a place for treatment of alcoholism or drug addiction. Confinement in a special unit of a Hospital used primarily as a nursing, rest, or convalescent home or an extended care facility is deemed with respect to the coverage provided by the Plan to be confinement in an institution other than a Hospital.

The term ***Hospital*** also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The types of procedures performed must permit discharge from the Center the same "working day." The Center will not qualify as a ***Hospital*** if:

1. Its primary purpose is performing abortions;
2. It is maintained as an office by a Physician for the practice of medicine; or
3. It is maintained as an office for the practice of dentistry.

Independent Freestanding Emergency Department means a facility that is geographically separate and distinct from a Hospital that is licensed under applicable State law to provide Emergency Services.

Injury means bodily injury caused by an accident resulting in loss, caused directly by such accident and independently of all other causes in loss covered by the Plan.

Intensive Care Unit means an accommodation that is a segregated section within a Hospital, which is specifically designed, permanently equipped and operated exclusively to provide extensive care for critically ill or injured patients and provides special supplies, equipment and constant

audiovisual observation and care by registered nurses (R.N.'s) or other Hospital personnel as prescribed by the attending Physician. It does not include any facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Maintenance Drug means a drug prescribed by a licensed provider for on-going, day-to-day treatment of a condition, which is expected to last more than thirty (30) days. Examples of Maintenance Drugs covered by the Plan include, but are not limited to, prescriptions requiring compounding and insulin. For current information about Maintenance Drugs covered by the Plan, contact Maxor Plus at 1-800-687-0707.

Maximum Allowable Amount means charges for medical care, services, or supplies Medically Necessary to your care, to the extent it does not exceed the general level of charges being made by providers of similar training and experience in the locality where the charge is incurred when finishing customary treatment for similar Sickness, condition, or Injury, whether in-network or out-of-network. The term "locality" means a county or such greater area as necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services, or supplies for which the charge was made. The Maximum Allowable Amount is based on Medicare's allowance at the 250th percentile and will not exceed that amount. Any out-of- network charges for non-Surprise Services above the reasonable, Maximum Allowable Amount are the responsibility of the Participant.

Medically Necessary means a medical or dental treatment that is required to identify or treat the Sickness or Injury that has been diagnosed by, or is reasonably suspected by, a Physician or other licensed provider, as required by law. The service must be consistent with currently accepted medical or dental practice and with the diagnosis and treatment of the condition, be in accordance with local standards of good medical practice, be required for reasons other than the person's or the Physician's or medical provider's convenience and be performed in the least costly setting required by your condition, and is not Experimental in nature. A treatment is not Medically Necessary just because it is recommended by your Physician, medical provider, or Dentist.

Medicare means benefits under Title XVIII of the Social Security Act of 1965, as amended from time to time.

Non-Participating Provider means a provider of medical or Hospital services, including a facility, that does not participate in the Empire BCBS network. For prescription drug claims, a non-participating provider refers to any pharmacy that does not participate in the Maxor Plus network of pharmacies. For vision benefits, a non-participating provider refers to an optician or optometrist that does not participate in the Vision Screening network and for dental services, any Dentist that does not participate in the DDS dental network.

Notice and Consent with respect Covered Services rendered by a Non-Participating Provider at a BCBS Provider Health Care Facility, Notice and Consent means: (1) that you are provided with a written notice consistent with the requirements of federal law (generally stating that the provider is a Non-Participating Provider, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any BCBS Providers at the facility who are able to treat you, and that you may elect to be referred to one of the BCBS Providers listed) and (2) you give informed consent to continued treatment by the Non-Participating Provider, acknowledging that you understand that continued treatment by the Non-Participating Provider may result in greater

cost to you.

Out-of-Network refers to any services, supplies or treatments rendered by a Non-Participating Provider.

Participant means an Employee on whose behalf contributions are made to the Fund and who has satisfied the Plan's eligibility rules.

Physician means a licensed doctor of medicine and acting within the scope of his or her license including a licensed chiropractor, who is not a Covered Person or a member of a Covered Person's immediate family (spouse, children, brothers, sisters, or parents of Covered Person).

Plan means this booklet, which describes the Plan of benefits of the Fund as it may be modified or amended from time to time.

Proof of Loss means the completed claim form along with all original, itemized bills or other documents required under the Plan, signed and certified by the claimant or, in the case of death, the deceased's beneficiary.

Qualified Medical Child Support Order or ***QMCSO*** means a medical child support order, which creates or recognizes the existence of a child's right to, or assigns to a child, who is eligible for coverage under the Plan, the right to, receive benefits under this Plan, and which complies with certain rules and regulations of ERISA, the Code and the Plan.

Qualified Payment Amount ("QPA") generally means the median of the in-network rates payable for a particular service as of a particular date, based on Empire BCBS' book of business. In all cases, QPA shall be determined consistent with the No Surprises Act and any regulations issued thereunder.

Room and Board means all charges commonly made by a Hospital on its own behalf for a room and meals and for general services and activities essential to the care of bed patients.

Separate Surgical Procedures means two or more necessary surgical procedures performed on the same day through the same incision and that are due to different and unrelated causes.

Serious and Complex Condition means: (1) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or (2) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Sickness means a non-occupational illness, condition or disease that requires treatment by a Physician or other licensed provider that causes a loss covered by the Plan.

Skilled Nursing Facility means a facility that mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. The facility must carry out its stated purpose under all relevant state and local laws and is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

Successive Periods of Confinement or Successive Surgical Procedures means two or more periods of Hospital confinement or surgical procedures due to the same or related causes and shall be considered one confinement or procedure unless (a) with respect to the Participant only, such Participant has returned to Covered Employment for at least one (1) full working day before the subsequent confinement or procedure begins, or (b) with respect to a Dependent only, they are separated by three (3) months or more.

Surprise Services means the following services, to the extent required by applicable law and to extent they are Covered Services under the Plan: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) non-emergency Ancillary Services when performed by Non-Participating Providers at BCBS Provider facilities; and (4) other out-of-network non-Emergency Services performed by a Non-Participating Provider at a BCBS Provider facility with respect to which the Notice and Consent requirements have not been met

Total Disability means inability to perform any of the substantial and material duties of the disabled person's occupation or employment. A child is considered to be totally disabled if, as the result of Injury or Sickness, he or she is confined to the house or in a Hospital. A Spouse will be considered totally disabled if, as the result of Injury or Sickness, the Spouse is unable to perform any of the regular routine activities normally performed by the Spouse.

Trustees means the members of the Board of Trustees of the Fund.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, and regulations thereunder, as amended from time to time.

GENERAL LIMITATIONS AND EXCLUSIONS

Each particular benefit section of this Plan will contain limitations and exclusions applicable to that particular benefit. In addition, listed below are limitations, exclusions, and circumstances applicable to all benefits provided under this Plan. To the extent a service listed below is otherwise required to be covered under applicable federal law, it is covered to the extent necessary to comply with such law.

(a) (1) Covered Person was not eligible for the benefits claimed.
(2) Covered Person failed to apply or make timely application for benefits.
(3) Covered Person failed to submit required evidence to substantiate a claim.
(4) Covered Person made material misstatements in connection with eligibility of the claim.
(5) Covered Person omitted facts or material statements as to other coverage available for the claim.
(6) Covered Person failed to seek relief under Worker's Compensation Laws, No-Fault Automobile Insurance, or similar legislation.
(7) The Employee's Contributing Employer fails to make timely contributions as required.

(b) No benefits will be paid by the Fund for charges or Expenses:
(1) Incurred as result of an Injury or Sickness arising out of or in the course of employment if (1) coverage is afforded under Worker's Compensation Laws or similar legislation, or (2) if the Covered Person receives compensation from the Contributing Employer for such Injury or Sickness, whether by judgment, settlement or compromise; or (3) the Board of Trustees determines that the Injury or Sickness arises out of employment.

(2) Which are not consistent with the diagnosis and treatment of the particular condition.

(3) that are for services which are not Medically Necessary or are performed by anyone other than a licensed provider acting within the scope of his/her license.

(4) For which mandatory No-Fault Automobile Insurance is payable.

(5) In connection with an accidental Injury sustained while driving an uninsured vehicle.

(6) In connection with Sickness or Injury incurred in, or as the result of, declared or undeclared war, rebellion, revolution, military service or civil disturbance.

(7) For any and all Expenses incurred as a result of pregnancy of a person covered as a Dependent child under this Plan, unless coverage is required by applicable federal law.

(8) Coverage for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

(9) Declared or undeclared war; or act of war;

(10) Expenses that are not approved by a Physician or other licensed provider, to the extent required by law.

(11) Cosmetic surgery. This does not apply to

a) Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or

b) Reconstructive surgery because of a congenital disease or anomaly of a Covered Person.

c) Reconstructive surgery to the extent required by applicable law.

(12) Eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses, except as provided in the Optical benefit;

(13) Glasses or contact lenses except contact lenses when required because of surgery, except as provided in the Optical benefit;

(14) Charges made by a health care provider if related to the Covered Person or living with the person requiring treatment;

(15) Expenses for medical treatment of temporomandibular joint disturbances;

(16) Surgery to the eye for refractive purposes;

(17) Educational training, equipment or supplies, except those mandated by law;

(18) Surgical procedures or treatment to alter a person's sex;

(19) Intentionally self-inflicted Injury or Sickness that is not the result of a medical condition;

(20) Treatment of infertility for in-vitro over 3 attempts during the lifetime of the Covered Person;

(21) Dental care and treatment except as provided in the Dental Section;

(22) Treatment which is determined to be Experimental or investigational, except to the extent required by applicable federal law.

(23) Care provided to you or your eligible Dependent(s) to the extent that the cost of the professional care or hospitalization may be recoverable by, or on behalf of, you or your eligible Dependent(s) in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you or your Dependent(s) may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, as provided in the "Subrogation and

Reimbursement" and "Right of Recovery" sections on pages 75-78 of this SPD.

(24) For services provided by BCBS Providers, diagnosis-related group charges that are in excess of the aggregate charges for the underlying billed services.

Any Expense incurred with respect to drugs or medicines that are covered in whole or in part under the "Prescription Drug Benefit" will not be considered a Covered Expense under any other section. Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance.

Expenses for all out-of-network charges that are not Surprise Services that are above the Maximum Allowable Amount are excluded from Fund coverage.

HOSPITAL EXPENSE BENEFIT

If a Covered Person is confined to a Hospital that is a BCBS Provider, Covered Services charged by the Hospital will be paid by the Fund at 100% of BCBS preferred provider option ("PPO") rate for the first 120 days of confinement during a calendar year and after that, the Fund will cover 50% of the PPO rate for any confinement for the next 180 days during the same calendar year. The Covered Person will be responsible to pay the remaining 50% of the PPO rate.

For confinement at a Hospital that is a Non-Participating Provider for Covered Services that are not Surprise Services, the Fund will pay 100% of the Maximum Allowable Amount for Covered Services charged by the Hospital during the first 120 days in any calendar year and will then pay 50% of the Maximum Allowable Amount for Covered Services charged by the Hospital for the next 180 days during the same year. The Covered Person will be responsible to pay the remaining 50%, as well as all charges that exceed the Maximum Allowable Amount.

For confinement at a Hospital that is a Non-Participating Provider for a Covered Service that is a Surprise Service, the Fund will pay 100% of the lesser of QPA or the actual billed charges for Covered Services provided by the Hospital during the first 120 days in any calendar year. For the next 180 days of confinement during the calendar year, you will be required to pay a Co-Insurance, equal to 50% of the lesser of QPA or the actual billed charges. For Surprise Services, you will not be required to pay more than the maximum amount allowed to be charged under applicable federal law. You will not be responsible for any amounts that exceed your Co-Insurance requirement.

The maximum Hospital benefit, whether at a BCBS Provider or not, is 300 days during any calendar year.

The Fund's Hospital benefit includes Room and Board and general nursing care. It also includes miscellaneous expenses, such as Hospital services and supplies, transportation in an ambulance to or from the Hospital; blood and blood plasma (except when it is replaced); and tests or X-rays for diagnostic purposes within the seven days immediately preceding a period of Hospital confinement, provided that (1) the tests are in connection with the Sickness or Injury from which the confinement results, (2) the tests would be covered, if performed during Hospital confinement, (3) the tests are administered in the Hospital in which confinement immediately follows, (4) the confinement is determined to be Medically Necessary before the administration of the tests or X-

rays, and (5) tests would have been covered if done as an in-patient.

For Ancillary Services, you will be required to pay a Co-Insurance equal to 20% of the lesser of QPA or the actual billed charges, but in no event more than the amount you would be required to pay to a BCBS Provider. If you would not be required to pay any out-of-pocket amount to a BCBS Provider for these types of services, you will have no out-of-pocket responsibility for the Ancillary Services. You will not be responsible for any amounts in excess of any Co-Insurance you are required to pay.

If you seek care at a Hospital emergency room for something that is not an Emergency Medical Condition, no coverage is provided by the Fund and you are responsible for the full cost of services.

In-patient Physical Therapy, Physical Medicine and Rehabilitation

The Fund will cover 100% of the PPO rate for in-patient physical therapy, physical medicine and rehabilitation rendered by a BCBS Provider. However, paraffin wax treatments are excluded from coverage.

For treatment rendered at a facility that does not participate in the BCBS network, the Fund will pay 80% of the Maximum Allowable Amount after satisfaction of the annual Deductible. Coverage will be provided for a maximum of 30 days in each calendar year. This maximum is combined with, and not in addition to, the maximum for all in-patient Hospital confinements, including confinement at a Skilled Nursing Facility. In addition, benefits are provided only when such services are performed under a program approved by the New York State Department of Health and only when the therapeutic confinement follows immediately from an eligible Hospital confinement and for which benefits were paid under this Plan. Notwithstanding, to the extent any such services are Surprise Services, the Covered Person will not have any out-of-pocket costs.

Physical Therapy

Participants without a Referral

If you feel you require physical therapy but do not have a medical referral from a treating Physician, the Fund will cover up 10 visits during a 30-day period, one time per calendar year. After 10 visits, you must receive pre-authorization for any further therapy sessions to be covered.

Participants with a Referral

If a Physician has referred you to physical therapy, the Fund will cover up to 12 visits within a 6-week period per injury or procedure per calendar year. If your Physician anticipates that you will require more than 12 visits, you should seek pre-authorization as soon as possible to avoid lapses in treatment.

Occupational Therapy

The Fund will cover up to 50 visits within a 6-month period, once per calendar year. After 50 visits, you must receive pre-authorization for any further therapy sessions to be covered.

Speech Therapy

The Fund will cover up to 50 visits within a 6-month period, once per calendar year. After 50 visits, you must receive pre-authorization for any further therapy sessions to be covered.

Chiropractic Care

The Fund will cover up to 12 visits within a 6-week period per illness/injury per calendar year. After 12 visits, you must receive pre-authorization for any further therapy sessions to be covered.

Skilled Nursing Facility Benefit

The Fund will cover 100% of the PPO rate for treatment rendered at a participating Skilled Nursing Care Facility and for any Surprise Services. For confinement at an Out-Of-Network Skilled Nursing Care Facility for non-Surprise Services, the Fund will pay 80% of the Maximum Allowable Amount after satisfaction of the annual Deductible. Coverage will be provided for a maximum of 30 days in each calendar year. This annual maximum is combined with, and not in addition to, the annual maximum for all in-patient Hospital confinements, including confinement at a physical therapy, physical medicine and rehabilitation facility. In addition, the following conditions must be met in order for treatment at a Skilled Nursing Care Facility to be covered under the Plan:

- The Covered Person requires skilled nursing care treatment;
- The Covered Person is transferred to the Skilled Nursing Care Facility within seven days of being discharged from a Hospital for which benefits were covered under this Plan; and
- The treatment provided at the Skilled Nursing Care Facility is consistent with the diagnosis and treatment of the condition that required the preceding in-patient Hospital confinement and such Hospital confinement was for at least 3 consecutive days.

Out-Patient Benefits

The Fund will pay for Covered Expenses incurred for out-patient Emergency Medical Services consistent with the requirements of applicable law.

The full Hospital Expense Benefit, as set forth in the Schedule of Benefits, will be available for each period of Hospital confinement that is not a Successive Period of Confinement, as defined on page 25.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for loss caused by or resulting from Hospital confinement or service that is not approved by a Physician.

Preventive and Primary Care Services

Preventative Care

The Fund covers preventive care services without any cost for you or your Dependents if rendered by a BCBS Provider. These services include annual physical exams and certain screenings, tests, vaccines, to the extent such services are included on the government's lists below, provided the services have been included on the list for at least one year prior to the Fund's Plan year. For example, if a preventive service was added to one of the lists in September 2023, it would be covered with no cost-sharing beginning January 1, 2025. The applicable lists are:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B;

- Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention; and

- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

You can access these lists at www.healthcare.gov.

Please note that the lists of preventive services include certain age, frequency, and other limitations that may affect your ability to receive coverage for the service without cost sharing. If you do not satisfy these limitations, you may incur out-of-pocket expenses.

MATERNITY LENGTH OF STAY

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods.

HOME HEALTH CARE EXPENSE BENEFIT

If a Covered Person incurs Home Health Care Expenses with a BCBS Provider, the Fund will pay 100% of the PPO rate for up to 40 visits per Covered Person per calendar year. For Home Health Care Expenses with a Non-Network Provider, the Fund will cover 75% of the Maximum Allowable Amount for Covered Services, up to a maximum of 40 visits per Covered Person per calendar year. This 40-visit maximum is for in-network and Out-of-Network Services combined.

Home Health Care Expenses

The charge must be made for services furnished in the patient's home by a Home Health Care Agency, and in accordance with a Home Health Care Plan.

Home Health Care Expenses may include:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse;

2. Visits by persons who have completed a Home Health Aide training course. The visit must be under the supervision of a Registered Nurse;

3. The following therapy:

   a. Physical

   b. Occupational; and

   c. Speech

4. Medical supplies, drugs and medications prescribed by a Physician or other licensed provider, to the extent required by law.

5. Laboratory services, to the extent such items would have been covered if the Covered Person had been in a Hospital.

Each visit by a member of a home health care team is considered one home health care visit. Four hours of home health aide service is considered as one home health care visit.

Limitations and Exclusions

No benefits are payable for:

1. Transportation services.

2. Any period during which the Covered Person is not under the care of a Physician or other licensed provider, except to the extent required by law.

3. Any visit for which Medicare has determined Home Health Care is unnecessary for the Covered Person.

4. No benefits are payable with respect to any Expenses incurred for a home health care visit which is covered in whole or in part under Medicare.

5. Home Health Care Expenses in excess of 40 visits in a calendar year.

SURGICAL EXPENSE BENEFIT

If, as a result of Sickness or Injury, a Covered Person undergoes a Medically Necessary surgical procedure, the Fund will pay the surgeon 100% of the PPO rate for services rendered by a BCBS Provider.

For services provided by a Non-Network Provider, the Fund will pay 100% up to the amount listed in the Schedule of Surgical Procedures for the procedure performed, and then 80% of the Maximum Allowable Amount, except that for Surprise Services, the Fund will pay the lesser of QPA or the actual billed charges and there is no out-of-pocket cost for the Covered Person.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for loss caused by or resulting from any of the following:

1. Any surgical procedure which is not approved by a Physician, or
2. Surgery in connection with dental care and treatment, except that made Medically Necessary by Injury.

ADDITIONAL SURGICAL OPINION

If an operation is recommended to treat a Sickness or Injury, the Covered Person may be required to obtain additional surgical opinions as to its need prior to the operation. For information on how to obtain an additional surgical opinion, please refer to the Pre- Certification/Managed Care and Second Surgical Opinion procedures beginning on page 2 of this SPD. For a second surgical opinion from either a BCBS Provider or a Non-Network Provider, the Fund will pay 100% of the billed charges, up to $150. Any charges in excess of $150 will not be covered. The opinion must be provided by a Board Certified Specialist in the surgical or medical specialty for which surgery is proposed and who has examined the patient in person in order for this to be a Covered Service.

This benefit will be payable only if the claim submitted is based on a written report from the Specialist. Benefits are not payable if the Specialist giving the opinion also performs the surgical procedure.

REPLACEMENT OF ORGANS/TISSUES AND RELATED SERVICES

If a Covered Person is a candidate for a Medically Necessary transplant procedure, contact American Health Holding before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under this Plan, before the actual services are rendered. Refer to the Pre-Certification/Managed Care and Second Surgical Opinion Section on page 2 for contact information. The Fund will cover such transplant services performed by a BCBS Provider at 100% of the PPO rate. For transplants performed by an Out-of-Network provider, the Fund will cover 100% of the Maximum Allowable Amount, after satisfaction of the annual Deductible.

If Medically Necessary, the following transplant procedures are considered Covered Expenses:

Solid Organs

Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This Plan excludes transplantation of non-human or artificial organs.

Bone Marrow Transplants

Benefits are provided for Medically Necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

The direct cost of the organ, organ procurement and donor-related medical services and procedures directly related to the transplant procedure are only covered when the recipient is enrolled in this Plan. Immunosuppressive Prescription Drugs are not covered unless covered under the Plan's Prescription Drug Plan.

Finding a donor who is an acceptable match for donation is important to the success of an allogenic/homologous bone marrow transplant. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow transplantation is Medically Necessary and is not considered Experimental or investigational. For purposes of this section, immediate family members include mother, father, biological children and biological siblings. If a donor match cannot be identified in the immediate family, the Plan will cover matching through a national registry.

Tissue Replacement

Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices).

Other Information Related to Transplantation

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow or tissue:

1. When the transplant recipient and donor are both covered under this Plan, payment for Covered Expenses is provided for both, subject to each Covered Person's respective benefit maximums.
2. When the transplant recipient is covered under this Plan but the donor is not, payment for Covered Expenses is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

Limitations and Exclusions

No benefits are payable for:

1. Any expenses incurred by or on behalf of the donor unless the recipient is a Covered Person under the Plan.

2. The preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.

3. Transportation of the Covered Person to and from the site of the transplant procedure.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Federal law provides that any group health plan that provides medical and surgical benefits with respect to a mastectomy, must also provide coverage for reconstructive surgery following the mastectomy as follows:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and physical complications of all stages of mastectomy, including lymphedema.

Such benefits are subject to the Plan's Deductibles and Coinsurance provisions.

GENE THERAPY EXPENSE BENEFIT

Benefits are provided for Medically Necessary, nonexperimental Gene Therapy. For the purposes of the Plan, Gene Therapy shall mean therapy that is approved by the Food and Drug Administration that involves introducing human DNA into an individual to treat a genetic disease. The new DNA usually contains a functioning gene to correct the effects of a disease- causing mutation. Non-human gene therapy is excluded from coverage. The Fund will cover gene therapy services performed by a BCBS Provider at 100% of the PPO rate. For gene therapy services performed by an Out-of-Network provider, the Fund will cover 80% of the Maximum Allowable Amount, after satisfaction of the annual Deductible.

Immunizations for Participants and Dependents Over the Age of 19

The Fund will provide 100% coverage of a BCBS Provider's rate for immunizations to Participants and Dependents over the age of 19, to the extent such services are included on the government's Recommended Immunizations of the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention; provided the services have been included on the list for at least one year prior to the Fund's Plan Year (which is the calendar year). Immunizations obtained from an Out-Of-Network provider will not be covered.

SCHEDULE OF OPERATIONS

PROCEDURE:	AMOUNT OF PAYMENT
ABDOMEN	
Appendectomy	$1,000.00
Removal of or other operation on gall bladder	1,500.00
Gastroenterostomy	1,500.00
Resection of stomach, bowel or rectum	2,000.00
ABSCESS	
Incision and Drainage (simple)	100.00
AMPUTATIONS	
Thigh, leg	1,250.00
Upper arm, forearm, hand or foot	1,000.00
Fingers or toes, each	150.00
BREAST	
Removal of benign tumor or cyst requiring Hospital residence	500.00
Simple amputation	1,000.00
Radical amputation	1,500.00
CHEST	
Complete thoracoplasty, transthoracic approach to stomach, diaphragm, or esophagus, sympathectomy or laryngectomy	2,000.00
Removal of lung or portion of lung	2,000.00
Bronchoscopy, escophagoscopy	
Diagnostic	400.00
Operative	500.00
Induction of artificial pneumothorax	
Initial	250.00
Refills, each (not more than 17)	100.00
DISLOCATION, REDUCTION OF	
Hip, ankle joint, elbow or knee joint (patella excepted)	350.00
Shoulder	250.00
Lower jaw, collar bone, wrist, patella	150.00

For a dislocation requiring an open operation, the maximum will be 2 times the amount shown above.

EXCISION OR FIXATION BY CUTTING

Hip joint 1,500.00
Shoulder, Semilunar cartilage, knee, elbow, wrist, ankle joint. 1,000.00
Removal of diseased portion of bone, including curettage (alveolar processes excepted) 500.00

EAR, NOSE OR THROAT

Fenestration, one or both ears.. 2,000.00
Mastoidectomy, one or both sides
    Simple 1,000.00
    Radical.. 1,500.00
Tonsillectomy, adenoidectomy, or both...300.00
Sinus operation by cutting (puncture of antrum excepted) 500.00
Submucous resection of nasal septum.. 500.00
Tracheotomy.. 500.00

EYE

Operation for detached retina.. 2,000.00
Cataract, removal of.. 1,500.00
Any other cutting operation into the eyeball (through the cornea or sclera) or cutting operation on eye muscles 1,000.00
Removal of eyeball 750.00

FRACTURE, TREATMENT OF

Thigh, vertebra or vertebrae, pelvis (coccyx excepted) 750.00
Leg, kneecap, upper arm, ankle (Potts), skull 500.00
Lower jaw
    (alveolar process excepted), collar bone shoulder blade, forearm, wrist (Colles) 250.00
Hand or foot 150.00
Fingers or toes, each.. 100.00
Nose.. 100.00
Rib or ribs
    Three or more 250.00
    Less than three 100.00

The amounts shown above are for simple fractures.

For a compound fracture the maximum payment will be 1½ times the amount shown above for the corresponding simple fracture.

For a fracture requiring an open operation, the maximum payment will be twice the amount shown above for the corresponding simple fracture (bone grafting or bone splicing and skeletal traction pin are considered as open operations).

GENITO-URINARY TRACT

Removal of or cutting into kidney 2,000.00
Fixation of kidney 1,500.00

Removal of tumors or stones in ureter or bladder
By cutting operation...1,000.00
By endoscopic means...350.00
Cystoscopy 250.00
Removal of prostate by open operation 1,000.00
Removal of prostate by endoscopic means 670.00
Circumcision 150.00
Varicocele, hydrocele, orchidectomy or epididymectomy
Single 500.00
Bilateral... 750.00
Hysterectomy 1,500.00
Cervix amputation.. 500.00
Dilation and curettage (non-puerperal) 250.00
Conization 250.00
Polypectomy (one or more).. 250.00
Cauterization
(where done separately and not in conjunction with any of the above procedures)....250.00

GOITRE
Removal of thyroid, subtotal. 1,500.00
Removal of adenoma or benign tumor of thyroid...1,000.00

HERNIA, REPAIR OF
Single hernia... 1,000.00
More than one hernia 1,250.00

JOINT
Incision into tapping excepted 250.00

LIGAMENTS AND TENDONS
Cutting or transplant
Single 500.00
Multiple... 750.00
Suturing of tendon
Single 350.00
Multiple... 500.00

PARACENTESIS
Tapping 150.00

PILONIDAL CYST OR SINUS
Removal of... 500.00

RECTUM
Colonoscopy or (procto) sigmoidoscopy
Diagnostic.. 100.00

With biopsy 150.00
With removal of polyp or polyps 150.00

Hemorrhoidectomy
External only 250.00
Internal only or internal and external 500.00

Cutting operation for fissure 250.00
Cutting operation for thrombosed hemorrhoids 150.00
Cutting operation for fistula in ano
Single 500.00
Multiple 750.00

SKULL

Cutting into cranial cavity (drill taps excepted) 2,000.00
Drill taps. 250.00

SPINE OR SPINAL CORD

Operation for spinal cord tumor 2,000.00
Operation with removal of portion of vertebra or vertebrae (except coccyx) 1,500.00
Removal of part or all of coccyx. 500.00

TUMORS, EXCISION OF

Benign or superficial tumors and cysts or abscesses
Requiring Hospital residence 250.00
Not requiring Hospital residence 100.00

Malignant tumors of face, kip or skin 500.00

VARICOSE VEINS

Injection treatment, complete procedure 400.00
Cutting operation, complete procedure
One leg 500.00
Both legs 800.00

OBSTETRICAL PROCEDURES

Normal delivery 1,000.00
Caesarean section 2,000.00
Extra-uterine pregnancy 1,200.00
Miscarriage 500.00

MEDICAL EXPENSE BENEFIT

If, as a result of Sickness or Injury, a Covered Person requires medical treatment by a Physician, the Fund will pay 100% of the PPO rate for services rendered by a BCBS Provider. For services by a Non-Participating Provider, the Fund will cover, at 100%, one visit per day, up to $40 per visit, subject to a $1,250 annual maximum. Once the Fund has paid $1,250 on behalf of a Covered Person for Out-of-Network medical expenses, then the Fund will cover 80% of the Maximum Allowable Amount of Out-of-Network Covered Services for medical Expenses for the remainder of the calendar year.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for loss caused by or resulting from Medical Expenses due to examination for eyeglasses.

Successive Treatments by a Physician

Successive treatments by a Physician due to the same or related causes will be considered as resulting from one Sickness or Injury unless:

1. Separated by a period of 3 months or more; or
2. In the case of an active Employee, the treatments are separated by a return to work on a full-time basis for a least 1 day;

and will be covered only if the Medical Expense Benefit is then in force as to the Covered Person.

X-Ray and Diagnostic Expense Benefit

If you (while not Hospital confined) receive Covered Services for laboratory tests or X-rays for the diagnosis of a Sickness or Injury, including the interpretation of such tests, the Fund will pay Expenses for Covered Services charged by a BCBS Provider at 100% of the PPO rate. For Surprise Services, the Fund will pay the lesser of 100% of QPA or actual billed charges, but in no case will you pay more than the amount you would have been required to pay if the Surprise Service was rendered by a BCBS Provider.

If the Covered Services are rendered by a Non-Participating Provider and are not a Surprise Service, the Fund will cover the first $40 of the billed charges at 100% and then 80% of the Maximum Allowable Amount thereafter, after satisfaction of the annual Deductible. Once you have paid $750 in Coinsurance (your 20% of the Maximum Allowable Amount) during a calendar year for this X-Ray and Diagnostic Benefit, the Fund will cover 100% of the Maximum Allowable Amount for that Covered Person for the remainder of the year for this benefit only. You will still be responsible for charges billed in excess of the Maximum Allowable Amount. Charges for the interpretation of such tests or X-rays also will be covered under this benefit.

Charges for diagnostic laboratory tests or X-rays otherwise covered under the Hospital Expense Benefit section for this Plan will not be covered under this section of the Plan.

Coverage includes cancer screening procedures as follows:

- annual chemical cytology examination for covered females ages 18 and over; and
- routine mammographic examinations
  - baseline mammogram age 35-39
  - a mammogram every 2 years ages 40-49, unless recommended more frequently by the attending Physician
  - an annual mammogram for females age 50 and over.

The age and frequency limits do not apply to covered females who have a prior history or familial history of breast cancer.

X-RAY AND RADIOACTIVE THERAPY EXPENSE BENEFIT

If a Covered Person while covered under the Plan undergoes:

1. X-ray treatment;
2. Radium treatment; or
3. Radioactive isotope treatment

the Fund will cover 100% of the PPO rate if the services are rendered by a BCBS Provider or if it is a Surprise Service, the lesser of 100% of QPA or actual billed charges. If services are rendered by a Non-Participating Provider and is not a Surprise Service, the Fund will pay 100% of the amount specified in the Schedule of X-Ray and Radioactive Treatments below and then 80% of the Maximum Allowable Amount, after satisfaction of the annual Deductible. Once you have paid $500 in Coinsurance (your 20% of the Maximum Allowable Amount) during a calendar year for this X-Ray and Radioactive Therapy Expense Benefit, the Fund will cover 100% of the Maximum Allowable Amount for that Covered Person for the remainder of the year for this benefit only. You will still be responsible for charges billed in excess of the Maximum Allowable Amount.

SCHEDULE OF X-RAY AND RADIOACTIVE TREATMENTS

Condition Treated	Maximum Amount of Payment Per Treatment
TELERADIOTHERAPY, including roentgen ray, teleradium, telecobalt, telecesium, betatron, etc.	$15.00
X-RAY THERAPY-less than 1,000 KVP and Telecesium	
Testicle	15.00
Uterine cervix	15.00
Breast, primary, inoperable	15.00
Recurrence of metastasis	15.00
Skin	30.00
Lip	30.00
Other neoplasm	15.00
SUPER-VOLTAGE X-RAY 1,000 kvp and higher	
Cobalt, betatron	20.00

RADIUM AND RADIOISOTOPES
(sealed sources), intracavity,
interstitial plaque or mold

Testile	225.00
Uterine cervix	175.00
Breast, primary, inoperable	175.00
Recurrence of metestasis	150.00
Skin	75.00
Lip	75.00
Other neoplasm	150.00

RADIOISOTOPES (non-sealed sources)
administered internally

Thyroid cancer	150.00
Ascites and pleural effusion due to malignancy	100.00
Metastic carcinoma of bone	100.00
Chronic leukemia	100.00
Prostatic cancer	150.00

If two or more treatments are given on the same day, the total amount payable for all of them will not exceed the benefit for the condition that has the largest maximum allowance.

If a Covered Person, while a Hospital out-patient, receives a treatment for which benefits are payable and the Physician's fee is included in the charge made by the Hospital; that part of the Hospital charge representing the Physician's fee will be recognized as a basis for a claim to the same extent as though such charge had been made by the Physician.

Limitations and Exclusions

No benefits are payable for Expenses incurred for diagnostic purposes or for the rental or purchase of radioactive substances.

Supplementary Expense Benefit

If a Covered Person incurs Covered Expenses as the result of an Injury, the Fund will pay such Expenses for Medically Necessary Treatment within 7 days from the date of the Injury.

Covered Expenses

If an Expense is covered under a different section of the Plan, benefits hereunder will be reduced by those payments. This reduction does not apply to payments under any Medical Benefit which may be part of the Plan. This benefit includes the following services:

1. Hospital charges for daily board and bed or room and services;

2. Professional local ambulance service charges for transportation to a Hospital;

3. Charges made by a Physician for medical care and treatment for performing a surgical procedure;

4. Charges made by a Registered Nurse;

5. Licensed Practical Nursing charges during Hospital confinement;

6. Charges made for the cost and administration of an anesthetic;

7. Charges made for:

   a. X-ray examinations;

   b. Microscopic tests; or

   c. Any laboratory tests or analyses made for diagnostic or treatment purposes;

8. Charges made for treatments by a physiotherapist; and

9. Charges for the following supplies;

   a. Drugs and medicines requiring the written prescription of a Physician and which must be dispensed by a licensed pharmacist;

   b. Blood and blood plasma, except when replaced;

   c. Artificial limbs or eyes (including replacements which are functionally necessary);

   d. Casts, splints, trusses, crutches and braces (except dental braces);

   e. Oxygen and rental of equipment for the administration of oxygen; and

   f. Rental of a wheelchair or Hospital type bed.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for Expenses with respect to drugs or medicines covered under the Prescription Drug Benefit.

ANNUAL PHYSICAL EXAMINATION

The Annual Physical Examination by a Physician is covered at 100% of the PPO negotiated rate with an BCBS Provider. If rendered by a Non-Participating Provider, the Fund will cover 100% of the Maximum Allowable Amount. The Annual Physical Examination includes:

Complete Physical Examination
Medical History & Report
Audio and Vision Exam
Complete Blood Chemistry, including sugar
nitrogen, protein
Complete Blood Count
Urinalysis

Pelvic Exam - every year
(Age 18 and older)
Pap Smear – annually
(age 18 and older)
Electrocardiogram
Chest X-rays
Mammography Screening at intervals
Shown in the Schedule of Benefits

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, there is no coverage under the Annual Physical Benefit for the following:

1. eye examinations for corrective lenses;
2. any examination performed more than one in a calendar year
3. examinations while an in-patient at a Hospital.

OTHER COVERED SERVICES

(a) The cost of purchasing one hair prosthesis as a result of hair loss following chemotherapy.

(b) The cost of specialty infant formula when medically necessary for a dependent child covered under the Plan.

(c) The cost of purchasing cold caps for chemotherapy patients when medically necessary.

Covered Expenses will be considered to be incurred when the applicable services are performed or the applicable purchases are made. These services are covered under the Major Medical Benefit, meaning that after satisfaction of the annual Deductible, the Fund will cover 80% of the Maximum Allowable Amount.

Covered Persons in the Same Accident (Common Deductible)

If Covered Expenses are incurred by two or more Covered Persons in the same family as a result of Injuries sustained in the same accident, the benefits payable under this coverage on account of these Injuries during the current and following calendar years will be paid as if the Expenses are being incurred by each Covered Person individually. However, a single Deductible amount will apply to the combined Covered Expenses incurred as a result of the accident for all these Covered Persons.

Any Covered Expenses that are not related to Injuries sustained in the accident will not be included with the combined Covered Expenses resulting from the accident for the purpose of satisfying any Deductible amount.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage under this section is provided for loss caused by or resulting from any of the following:

1. Dental care and treatment
2. Expenses which have been paid or are payable under any other Section of this Plan;
3. Drugs and medicines used primarily for cosmetic purposes.
4. Charges billed in excess of any and all Plan limits.

MENTAL, NERVOUS AND EMOTIONAL DISORDER AND AILMENT BENEFIT

The Fund will cover the cost of Covered Services in connection with a mental, nervous or emotional disorder, as follows:

1. **In-patient**: In the event Expenses are incurred in connection with confinement as an in-patient in a Hospital, (including an institution defined as a Hospital in subdivision 11 of section 1.05 of the mental hygiene law of the State of New York), then the medical care and treatment of benefits provided will be the same as benefits for any other Sickness. The maximum period payable is listed in the Schedule of Benefits;
2. **Out-patient**: In the event Expenses are incurred as an out-patient for services furnished by:
    a. A Hospital;
    b. A facility issued an operating certificate by the commissioner of mental hygiene of the State of New York;

c. A facility operated by the office of mental health;

d. A psychologist licensed to practice in the State of New York or a professional corporation thereof; or

e. By a Physician at any location;

then the medical care and treatment benefits provided will be the same as benefits for any other Sickness. The maximum benefit and the maximum period payable are listed in the Schedule of Benefits.

3. **Out-patient Crisis Intervention**: In the event Expenses are incurred for treatment of a psychiatric emergency, as determined in the sole and absolute discretion of the Fund, any treatment will be covered by the Fund on the same terms and conditions as any other emergency.

   Any benefits paid for Out-patient Crisis Intervention services will be used to reduce any benefits otherwise payable under the In-patient or Out-patient benefits described above.

"Mental, Nervous and Emotional Disorders and Ailments" means disorders as described in the standard nomenclature of the American Psychiatric Association.

ALCOHOL AND SUBSTANCE ABUSE EXPENSE BENEFIT

The Plan covers Expenses for necessary treatment or services in connection with alcoholism or substance abuse, as follows, to the same extent as they would be payable for any other Sickness:

1. **In-patient**: Confinement for the purpose of detoxification or rehabilitation may be in an Alcoholism Treatment Center for the Covered Person whose primary diagnosis is alcohol abuse or dependency; or a Substance Abuse Treatment Center for the Covered Person whose primary diagnosis is substance abuse or dependence. You may select any licensed Alcoholism Treatment Center and Substance Abuse Treatment Center.

2. **Out-patient**: Out-patient visits for the purpose of rendering:

   a. Diagnostic;

   b. Medical;

   c. Therapeutic; and/or

   d. Counseling and education services.

The maximum benefit and period covered are the same as for any other Sickness and are listed in the Schedule of Benefits.

Definitions

For purposes of this benefit:

1. **"Alcoholism Treatment Center"** means:

   a. A facility which provides a program for the in-patient or out-patient treatment of alcoholism; and

   b. Which is certified as an alcoholism treatment facility by the division of alcoholism and alcohol abuse.

2. **"Substance Abuse Treatment Center"** means:

   a. A facility that provides a medically supervised ambulatory program for the treatment of substance abuse or substance dependence; and

   b. That is certified as a substance abuse treatment facility by the division of substance abuse services.

OPTICAL BENEFIT

The Optical Expense Benefit provides for one complete eye examination by an Optometrist through Vision Screening, Inc. to the extent necessary for correction and improvement of sight, and a pair of lenses and basic frame, if glasses are prescribed as a result of such examination. These benefits are provided for each Covered Person once every calendar year up to the amount shown on the Schedule of Benefits. The comprehensive eye exam includes; general case history; internal and external ocular exam; tonometry (glaucoma testing) and follow-up; habitual visual acuity; retinoscopy; subjective and objective refraction; cover test; phorias; fusion test; prescription, muscular and binocular coordination testing.

The Fund will cover the full cost of such examination with provider that participates in the Vision Screening network. If, as a result of such an examination, the in-network Optometrist prescribes a pair of lenses and a basic frame, the Fund will cover the full cost of such glasses, including:

(a) choice of frames;

(b) FDA impact resistant lenses meeting standards of American National Standards Institute;

(c) contact lenses.

If you receive optical services from an Out-Of-Network provider, up to $350.00 will be paid towards the cost of the eye examination and for a pair of lenses and basic frames.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no payment of benefit will be authorized for:

1. Dispensing of eyeglasses rendered by other than a duly licensed optometric or certified ophthalmic dispenser.

2. Lens prescription issued by someone other than a licensed optometrist within the scope of his/her license.

3. Prescription lenses other than glass or plastic single vision lenses or glass or plastic bifocal lenses.

4. Except as otherwise required by law, vision care Expenses in excess of $350.00 per claimant per year.

5. No benefits are payable for treatment which is determined to be Experimental or for conditions arising out of or in the course of employment.

How Do I Get Optical Benefits?

Please call the Fund Office to request an Optical Voucher. You may present this Optical Voucher at any of the participating optical centers. The Fund office should be contacted by phone or mail for a list of participating optical centers.

DENTAL EXPENSE BENEFIT

The Dental Expense Benefit provides for a wide range of dental procedures provided by a Dentist through D. D. Services ("DDS"), in accordance with the schedule shown on the following pages. If a Covered Person uses a provider that is not a member of the DDS panel of providers, the Dental Expense Benefit will be paid up to the amount that would be paid to a DDS panel provider and you are responsible for any remaining amounts owed.

Limitations and Exclusions

In addition to the Limitations and Exclusions applicable to all forms of benefits, no coverage is provided for losses caused by or resulting from any of the following:

1. Dental charges in excess of the maximum stated in the Schedule of Benefits;

2. Dental services not specifically shown on the schedule contained herein;

3. Dental claims in excess of $300.00 that are not approved by peer review prior to treatment;

4. Replacement of lost or stolen appliances;

5. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition;

6. A service not furnished by a Dentist, except;

   (a) That is performed by a licensed dental hygienist under a Dentist's supervision; and

   (b) X-rays ordered by a Dentist

7. The replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within 5 years of the date of the last placement of such items unless replacement is needed as a result of Injury;

Orthodontic procedures must start prior to attaining age 19 but after attaining age 8, otherwise they are not covered.

No payment will be made by the Fund for dental services or supplies furnished on or after the date of termination of a coverage, except under the following specified circumstances:

1. In the case of appliances or modifications of appliances, if the master impression was taken while dental coverage was in force, benefits will be payable if the appliance was delivered or installed within 2 calendar months after the termination of insurance;

2. In the case of a crown, bridge, or inlay or onlay restorations, if the tooth or teeth were prepared while dental coverage was in force, benefits will be payable if such crown, bridge or cast restoration was installed within 2 calendar months after the termination of coverage;

3. In the case of root canal therapy, if the pulp chamber was opened while dental coverage was in force, benefits will be payable if such root canal therapy is completed within 2 calendar months after the termination of coverage;

4. In the case of orthodontic treatment, treatment must have started while dental coverage was in force under the policy. Benefits will be payable for orthodontic treatment Expenses incurred during the 2-month period after the termination of coverage.

SCHEDULE OF DENTAL BENEFITS

CODE	DESCRIPTION	FEE
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PT.	$43.00
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	$43.00
D0145	ORAL EVALUATION FOR PATIENT UNDER 3 YRS.	$43.00
D0150	COMPREHENSIVE ORAL EVALUATION	$58.00
D0160	DETAILED/EXTENSIVE EVALUATION-PROBLEM	$58.00
D0170	RE-EVALUATION-LIMITED,PROBLEM FOCUSED	$43.00
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	$58.00
D0190	SCREENING OF A PATIENT	$30.00
D0191	ASSESSMENT OF A PATIENT	$20.00
D0210	INTRAORAL-COMPLETE SERIES	$110.00
D0220	INTRAORAL-PERIAPICAL,FIRST IMAGE	$25.00
D0230	INTRAORAL-PERIAPICAL,EACH ADDL.IMAGE	$20.00
D0240	INTRAORAL-OCCLUSAL RADIOGRAPHIC IMAGE	$41.00
D0250	EXTRA-ORAL 2D PROJECTION RADIOGRAPHIC IM	$57.00
D0251	EXTRA-ORAL POSTERIOR RADIOGRAPHIC IMAGE	$53.00
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	$18.00
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	$34.00
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	$47.00
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	$58.00
D0277	VERTICAL BITEWINGS-7 TO 8 IMAGES	$58.00
D0310	SIALOGRAPHY	$103.00
D0320	TMJ IMAGE,INCLUDING INJECTION	$263.00
D0321	OTHER TMJ IMAGES,BY REPORT	$163.00
D0322	TOMOGRAPHIC SURVEY	$261.00
D0330	PANORAMIC RADIOGRAPHIC IMAGE	$96.00
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGE-ACQ	$97.00
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGE	$41.00
D0360	CONE BEAM CT-CRANIOFACIAL DATA CAPTURE	$375.00
D0362	CONE BEAM-TWO-DIMENSIONAL IMAGE-MULTIPLE	$315.00
D0363	CONE BEAM-THREE-DIMENSIONAL IMAGE-MULTIP	$315.00
D0364	CONE BEAM CT CAPTURE-LESS THAN ONE JAW	$165.00
D0365	CONE BEAM CT CAPTURE-OF FULL ARCH-MAND	$346.00
D0366	CONE BEAM CT CAPTURE-MAX W/W/OUT CRANIUM	$346.00
D0367	CONE BEAM CT CAPTURE-BOTH JAWS	$260.00
D0368	CONE BEAM CT CAPTURE FOR TMJ SERIES	$351.00
D0380	CONE BEAM CT-LIMITED-LEES THAN ONE JAW	$335.00
D0381	CONE BEAM CT IMAGE-FULL ARCH-MANDIBLE	$353.00
D0382	CONE BEAM CT-1 FULL ARCH-MAXILLA	$353.00
D0383	CONE BEAM CT IMAGE CAPTURE-BOTH JAWS	$335.00

D0384	CONE BEAM CT FOR TMJ-2 OR MORE EXPOSURES	$355.00
D0415	COLLECTION OF MICROORGANISMS	$43.00
D0423	GENETIC TEST FOR SUSCEPTIBILITY TO DISEA	$42.00
D0431	ADJUNCTIVE PRE-DIAGNOSTIC TEST	$35.00
D0460	PULP VITALITY TESTS	$44.00
D0470	DIAGNOSTIC CASTS	$84.00
D0472	ACCESSION OF TISSUE,GROSS EXAMINATION	$64.00
D0473	ACCESSION OF TISSUE MICROSCOPIC EXAM	$64.00
D0474	ACCESSION OF TISSUE FOR DISEASE	$64.00
D0480	ACCESSION OF EXFOLIATIVE CYTLOLGIC SMEAR	$64.00
D0486	LABORATORY ACCESSION-TRANSEPITHELIAL CYT	$64.00
D0502	OTHER ORAL PATHOLOGY PROCEDURES,BY RPT	$67.00
D1110	PROPHYLAXIS-ADULT	$84.00
D1120	PROPHYLAXIS-CHILD	$60.00
D1206	TOPICAL FLUORIDE VARNISH-THERA	$48.00
D1208	TOPICAL APPLICATION OF FLUORIDE-UNDER 14	$37.00
D1310	NUTRITIONAL COUNSELING-DISEASE CONTROL	$22.00
D1320	TOBACCO COUNSELING-CNTRL/PREVENT DISEASE	$28.00
D1330	ORAL HYGIENE INSTRUCTIONS	$34.00
D1351	SEALANT-PER TOOTH	$64.00
D1352	PREVENTIVE RESIN RESTORATION-PERM TTH	$35.00
D1353	SEALANT REPAIR-PER TOOTH	$30.00
D1510	SPACE MAINTAINER-FIXED-UNILATERAL-QUAD	$332.00
D1516	SPACE MAINTAINER-FIXED-BILATERAL,MAX.	$432.00
D1517	SPACE MAINTAINER-FIXED BILATERAL,MAND.	$432.00
D1520	SPACE MAINTAINER-REMOVABLE-UNILATERAL-QD	$293.00
D1525	SPACE MAINTAINER-REMOVABLE-BILATERAL	$535.00
D1526	SPACE MAINTAINER-REMOVABLE-BILATERAL,MAX	$535.00
D1527	SPACE MAINTAINER-REMOVABLE-BILATERAL,MND	$535.00
D1551	RE-CEMENT/RE-BOND BILATERAL SPACE MAINT.	$61.00
D1552	RE-CEMENT/RE-BOND BILATERAL SPACE MAINT.	$61.00
D1553	RE-CEMENT/RE-BOND UNILATERAL SPACE MAINT	$43.00
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINT.	$52.00
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINT.	$52.00
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINT.	$52.00
D1575	DISTAL SHOE SPACE MAINT.FIXED-UNILATERAL	$332.00
D2140	AMALGAM-ONE SURFACE,PRIMARY OR PERMANENT	$86.00
D2150	AMALGAM-TWO SURFACES,PRIMARY OR PERMAN'T	$121.00
D2160	AMALGAM-THREE SURFACES,PRIMARY OR PERM.	$156.00
D2161	AMALGAM-FOUR OR MORE SURFACES,PRIM,PERM	$194.00
D2330	COMPOSITE-ONE SURFACE,ANTERIOR	$115.00
D2331	COMPOSITE-TWO SURFACES,ANTERIOR	$156.00

D2332	COMPOSITE-THREE SURFACES,ANTERIOR	$193.00
D2335	COMPOSITE-FOUR OR MORE SURF	$223.00
D2390	RESIN COMPOSITE CROWN,ANTERIOR	$223.00
D2391	COMPOSITE-ONE SURFACE,POSTERIOR	$97.00
D2392	COMPOSITE-TWO SURFACES,POSTERIOR	$133.00
D2393	COMPOSITE-THREE SURFACES,POSTERIOR	$174.00
D2394	COMPOSITE-FOUR OR MORE SURF.,POSTERIOR	$175.00
D2410	GOLD FOIL-ONE SURFACE	$249.00
D2420	GOLD FOIL-TWO SURFACES	$343.00
D2430	GOLD FOIL-THREE SURFACES	$411.00
D2510	INLAY-METALLIC-ONE SURFACE	$545.00
D2520	INLAY-METALLIC-TWO SURFACES	$726.00
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	$846.00
D2542	ONLAY-METALLIC-TWO SURFACES	$726.00
D2543	ONLAY-METALLIC-THREE SURFACES	$944.00
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	$944.00
D2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	$589.00
D2620	INLAY-PORCELAIN/CERAMIC-TWO SURFACES	$744.00
D2630	INLAY-PORCELAIN/CERAMIC-THREE OR MORE SU	$846.00
D2642	ONLAY-PORCELAIN/CERAMIC-TWO SURFACES	$944.00
D2643	ONLAY-PORCELAIN/CERAMIC-THREE SURFACES	$944.00
D2644	ONLAY-PORCELAIN/CERAMIC-FOUR OR MORE SUR	$944.00
D2650	INLAY-RESIN-BASED COMPOSITE-ONE SURFACE	$434.00
D2651	INLAY-RESIN-BASED COMPOSITE-TWO SURFACES	$504.00
D2652	INLAY-RESIN-BASED COMPOSITE-THREE OR MOR	$562.00
D2662	ONLAY-RESIN-BASED COMPOSITE-TWO SURFACES	$944.00
D2663	ONLAY-RESIN-BASED COMPOSITE-THREE SURFAC	$944.00
D2664	ONLAY-RESIN-BASED COMPOSITE-FOUR OR MORE	$944.00
D2710	CROWN-RESIN-BASED COMPOSITE (INDIRECT)	$378.00
D2712	CROWN-3/4 RESIN-BASED COMP.(INDIRECT)	$269.00
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	$974.00
D2721	CROWN-RESIN W/PREDOMINATELY BASE METAL	$856.00
D2722	CROWN-RESIN WITH NOBLE METAL	$913.00
D2740	CROWN-PORCELAIN/CERAMIC	$1,004.00
D2750	CROWN-PORCELAIN FUSED HIGH NOBLE METAL	$1,039.00
D2751	CROWN-PORCELAIN PREDOMINATELY BASE METAL	$914.00
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	$991.00
D2753	CROWN-PORCELAIN-TITANIUM/TITANIUM ALLOYS	$914.00
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	$1,012.00
D2781	CROWN-3/4 CAST PREDOMINATELY BASE METAL	$889.00
D2782	CROWN-3/4 CAST NOBLE METAL	$889.00
D2783	CROWN-3/4 PORCELAIN/CERAMIC	$1,004.00

D2790	CROWN-FULL CAST HIGH NOBLE METAL	$1,012.00
D2791	CROWN-FULL CAST PREDOMINATELY BASE METAL	$889.00
D2792	CROWN-FULL CAST NOBLE METAL	$889.00
D2794	CROWN-TITANIUM AND TITANIUM ALLOYS	$1,012.00
D2799	INTERIM CROWN-NOT TO BE USED FOR TEMP.	$274.00
D2910	RE-CEMENT/RE-BOND INLAY,ONLAY,VENEER,PRT	$80.00
D2915	RE-CEMENT/RE-BOND FAB/PREFAB POST & CORE	$73.00
D2920	RE-CEMENT OR RE-BOND CROWN	$73.00
D2930	PREFABRICATED SS CROWN-PRIMARY	$218.00
D2931	PREFABRICATED STAINLESS STEEL CROWN-PERM	$229.00
D2932	PREFABRICATED RESIN CROWN	$159.00
D2933	PREFAB.STAINLESS STEEL CRWN-RESIN WINDOW	$225.00
D2934	PREFAB.ESTHETIC SS CROWN-PRIMARY	$218.00
D2940	PROTECTIVE RESTORATION	$74.00
D2950	CORE BUILDUP,INCLUDING ANY PINS	$124.00
D2951	PIN RETENTION-PER TOOTH	$56.00
D2952	POST AND CORE	$332.00
D2953	EACH ADDITIONAL POST-SAME TOOTH	$250.00
D2954	PREFABRICATED POST AND CORE	$277.00
D2955	POST REMOVAL	$209.00
D2957	EACH ADDL.PREFABRICATED POST-SAME TOOTH	$209.00
D2960	LABIAL VENEER (RESIN LAMINATE)-DIRECT	$320.00
D2961	LABIAL VENEER (RESIN LAMINATE)-INDIRECT	$702.00
D2962	LABIAL VENEER(PORCE.LAMINATE)-INDIRECT	$764.00
D2971	ADDL.PROC.FOR NEW CRWN.UNDER PRTL.DENT.	$104.00
D2980	CROWN REPAIR DUE TO RESTORATIVE FAILURE	$148.00
D2981	INLAY REPAIR DUE TO RESTORATIVE FAILURE	$134.00
D2982	ONLAY REPAIR DUE TO RESTORATIVE FAILURE	$134.00
D2983	VENEER REPAIR DUE TO RESTORATIVE FAILURE	$134.00
D2990	RESIN INFILTRATION-INCIPIENT SMOOTH SURF	$35.00
D3110	PULP CAP-DIRECT	$47.00
D3120	PULP CAP-INDIRECT	$43.00
D3220	THERAPEUTIC PULPOTOMY	$122.00
D3221	PULPAL DEBRIDEMENT,PRIMARY/PERMANENT TTH	$63.00
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS-PERM.	$122.00
D3230	PULPAL THERAPY,ANTERIOR-PRIMARY TOOTH	$215.00
D3240	PULPAL THERAPY,POSTERIOR-PRIMARY TOOTH	$264.00
D3310	ROOT CANAL,ANTERIOR TOOTH	$494.00
D3320	ROOT CANAL,PREMOLAR TOOTH	$565.00
D3330	ROOT CANAL,MOLAR TOOTH	$790.00
D3331	TRMNT-ROOT CANAL OBSTRUCTION-NON SURGICA	$133.00
D3332	INCOMPLETE ENDO.THERAPY-UNRESTORABLE TTH	$271.00

D3333	INTERNAL ROOT REPAIR PERFORATION DEFECTS	$112.00
D3346	RETREATMENT OF ROOT CANAL-ANTERIOR TTH	$700.00
D3347	RETREATMENT OF ROOT CANAL-PREMOLAR TOOTH	$850.00
D3348	RETREATMENT OF ROOT CANAL-MOLAR TOOTH	$980.00
D3351	APEXIFICATION/RECALCIFICATION-INITIAL	$213.00
D3352	APEXIFICATION/RECALCIFICATION-INTERIM	$109.00
D3353	APEXIFICATION/RECALCIFICATION-FINAL	$408.00
D3355	PULPAL REGENERATION-INITIAL VISIT	$133.00
D3410	APICOECTOMY-ANTERIOR	$480.00
D3421	APICOECTOMY-PREMOLAR,1ST ROOT	$494.00
D3425	APICOECTOMY-MOLAR,1ST ROOT	$564.00
D3426	APICOECTOMY-EACH ADDITIONAL ROOT	$213.00
D3430	RETROGRADE FILLING-PER ROOT	$128.00
D3450	ROOT AMPUTATION-PER ROOT	$328.00
D3470	INTENTIONAL RE-IMPLANTATION	$454.00
D3471	SURGICAL REPAIR ROOT RESORPTION-ANTERIOR	$480.00
D3472	SURGICAL REPAIR ROOT RESORPTION-PREMOLAR	$480.00
D3473	SURGICAL REPAIR OF ROOT RESORPTION-MOLAR	$480.00
D3910	SURGICAL PROCEDURE-ISOLATION OF TOOTH	$140.00
D3920	HEMISECTION-NOT INCLUDING ROOT CANAL	$278.00
D3950	CANAL PREPARATION & FITTING-DOWEL/POST	$106.00
D4210	GINGIVECTOMY/GINGIVOPLASTY-PER QUAD	$396.00
D4211	GINGIVECTOMY/GINGIVOPLASTY-1-3 TEETH	$189.00
D4212	GINGIVECTOMY/PLASTY-ALLOW ACCESS-PER TTH	$155.00
D4230	ANATOMICAL CROWN EXPOSURE-4+TTH-PER QUAD	$637.00
D4231	ANATOMICAL CROWN EXPOSURE-1-3 TH PR QUAD	$382.00
D4240	GINGIVAL FLAP PROCEDURE-PER QUAD	$515.00
D4241	GINGIVAL FLAP PROCEDURE-1-3 TEETH	$309.00
D4245	APICALLY POSITIONED FLAP	$515.00
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	$629.00
D4260	OSSEOUS SURGERY-PER QUADRANT	$849.00
D4261	OSSEOUS SURGERY-1 TO 3 TEETH	$509.00
D4263	BONE REPLACEMENT GRAFT-1ST SITE IN QUAD	$363.00
D4264	BONE REPLACEMENT GRAFT-EACH ADDL.SITE	$436.00
D4265	BIOLOGIC MATERIALS-AID SOFT/OSSEOUS TISS	$779.00
D4266	GUIDED TISSUE REGENERATION-NON-RESTORABL	$297.00
D4267	GUIDED TISSUE REGENERATION-NONRESTORABLE	$380.00
D4268	SURGICAL REVISION PROCEDURE-PER TOOTH	$190.00
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$545.00
D4273	AUTOGENOUS CONNECTIVE TISS.GRFT.PROC.INC	$747.00
D4274	MESIAL/DISTAL WEDGE PROCEDURE-SINGLE TTH	$228.00
D4275	NON-AUTOGENOUS CONNECTIVE TISS.GRFT.IN CL	$726.00

D4276	COMBINED CONNECTIVE TISSUE/PEDICLE GRAFT	$811.00
D4277	FREE SOFT TISSUE GRAFT PROCEDURE-1ST TTH	$800.00
D4278	FREE SOFT TISSUE GRFT PROC-EACH ADDL TH	$700.00
D4283	AUTOGENOUS CONNECTIVE TISS.GRFT.PROC.INC	$325.00
D4285	NON-AUTOGENOUS CONNECTIVE TISS.GRFT.EA.A	$148.00
D4322	SPLINT-INTRA-CORONAL-NATURAL OR PROS.CR	$208.00
D4323	SPLINT-EXTRA-CORONAL-NATURAL OR PROS.CR	$208.00
D4341	PERIODONTAL SCALING/ROOT PLANING-QUAD	$135.00
D4342	PERIODONTAL SCALING/ROOT PLANING-1-3 TH	$85.00
D4355	FULL MOUTH DEBRIDEMENT-SUBSEQUENT VISIT	$110.00
D4381	LOCALIZED DELIVERY ANTIMICROBIAL AGENTS	$83.00
D4910	PERIODONTAL MAINTENANCE PROCEDURE	$100.00
D4920	UNSCHEDULED DRESSING CHANGE	$42.00
D4921	GINGIVAL IRRIGATION-PER QUADRANT	$45.00
D5110	COMPLETE DENTURE-MAXILLARY	$1,009.00
D5120	COMPLETE DENTURE-MANDIBULAR	$1,009.00
D5130	IMMEDIATE DENTURE-MAXILLARY	$1,110.00
D5140	IMMEDIATE DENTURE-MANDIBULAR	$1,110.00
D5211	MAXILLARY PARTIAL DENTURE-RESIN BASE	$771.00
D5212	MANDIBULAR PARTIAL DENTURE-RESIN BASE	$771.00
D5213	MAXILLARY PARTIAL DENTURE-CAST BASE	$1,160.00
D5214	MANDIBULAR PARTIAL DENTURE-CAST BASE	$1,160.00
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE	$761.00
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE	$761.00
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE-CAST	$1,001.00
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE-CAS	$972.00
D5225	MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE	$751.00
D5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE	$729.00
D5227	IMMEDIATE MAXILLARY PARTIAL-FLEXIBLE BAS	$761.00
D5228	IMMEDIATE MANDIBULAR PARTIAL FLEXIBLE BA	$761.00
D5282	REMOVABLE UNILATERAL PRTL.DENT-1PC-MAX.	$597.00
D5283	REMOVABLE UNILATERAL PRTL.DENT.1PC-MAND.	$597.00
D5284	REMOV.UNILAT.PRTL.DENT-1PC.FLEXIBLE-QUAD	$597.00
D5286	REMOVABLE UNILATER PRTL-1 PC.RESIN-QUAD	$597.00
D5410	ADJUST COMPLETE DENTURE-MAX	$74.75
D5411	ADJUST COMPLETE DENTURE-MAND	$74.75
D5421	ADJUST PARTIAL DENTURE-MAX	$74.75
D5422	ADJUST PARTIAL DENTURE-MAND	$74.75
D5511	REPAIR BROKEN COMPLETE DENTURE BASE-MAND	$147.00
D5512	REPAIR BROKEN COMPLETE DENTURE BASE-MAX.	$147.00
D5520	REPLACE MISS/BRKN TTH-COMP DNT	$123.00
D5611	REPAIR RESIN PARTIAL DENTURE BASE-MAND.	$110.00

D5612	REPAIR RESIN PARTIAL DENTURE BASE-MAX.	$110.00
D5621	REPAIR CAST PARTIAL FRAMEWORK-MANDIBULAR	$131.00
D5622	REPAIR CAST PARTIAL FRAMEWORK-MAXILLARY	$131.00
D5630	REPAIR OR REPLACE BROKEN CLASP	$118.00
D5640	REPLACE BROKEN TEETH-PER TOOTH	$124.00
D5650	ADD TOOTH TO PARTIAL DENTURE	$128.00
D5660	ADD CLASP TO PARTIAL DENTURE	$170.00
D5670	REPLACE ALL TTH-PRTL DENT-MAX.	$629.00
D5671	REPLACE ALL TTH-PRTL DENT MAND	$629.00
D5710	REBASE COMPLETE DENTURE-MAX	$383.00
D5711	REBASE COMPLETE DENTURE-MAND	$372.00
D5720	REBASE PARTIAL DENTURE-MAX	$335.00
D5721	REBASE PARTIAL DENTURE-MAND	$335.00
D5725	REBASE HYBRID PROSTHESIS-REPLACE BASE MA	$207.00
D5730	RELINE COMPLETE DENT-MAX-CHAIR	$213.00
D5731	RELINE COMPLETE DNT-MAND-CHAIR	$213.00
D5740	RELINE PARTIAL DENT-MAX-CHAIR	$195.00
D5741	RELINE PARTIAL DENT-MAND-CHAIR	$195.00
D5750	RELINE COMPLETE DENT-MAX-LAB	$321.00
D5751	RELINE COMPLETE DENT-MAND-LAB	$321.00
D5760	RELINE PARTIAL DENT-MAX-LAB	$278.00
D5761	RELINE PARTIAL DENT-MAND-LAB	$278.00
D5765	SOFT LINER PLACEMENT-COMPLETE/PARTIAL DT	$226.00
D5810	INTERIM COMPLETE DENTURE-MAX	$481.00
D5811	INTERIM COMPLETE DENTURE-MAND	$481.00
D5820	INTERIM PARTIAL DENTURE-MAX	$383.00
D5821	INTERIM PARTIAL DENTURE-MAND	$372.00
D5850	TISSUE CONDITIONING-MAXILLARY	$101.00
D5851	TISSUE CONDITIONING-MANDIBULAR	$101.00
D5862	PRECISION ATTACHMENT,BY REPORT	$334.00
D5863	OVERDENTURE-COMPLETE MAXILLARY	$1,291.00
D5864	OVERDENTURE-PARTIAL MAXILLARY	$1,198.00
D5865	OVERDENTURE-COMPLETE MANDIBULAR	$1,291.00
D5866	OVERDENTURE-PARTIAL MANDIBULAR	$1,198.00
D5867	REPL.PART-PRECISION ATTACHMENT	$148.00
D5875	MODIFY REMOV.PROS.POST IMPLANT	$158.00
D6010	SURG.PLCMT.IMPLANT BODY-ENDOST	$1,695.00
D6011	SECOND STAGE IMPLANT SURGERY	$500.00
D6012	SURGICAL PLACEMENT INTERIM IMPLANT BODY	$1,695.00
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	$862.50
D6040	SURG.PLCMT.EPOSTEAL IMPLANT	$3,247.65
D6050	SURG.PLCMT.TRANSOSTEAL IMPLANT	$3,970.05

D6051	INTERIM IMPLANT ABUTMENT PLACEMENT	$345.00
D6055	CONNECTING BAR	$735.00
D6056	PREFAB.IMPLANT ABUTMENT	$594.30
D6057	CUSTOM IMPLANT ABUTMENT	$767.55
D6058	ABUT.SUPPORT.PORCE/CERAMIC-CRN	$1,110.90
D6059	ABUT.SUPPORT.PORCE.HIGH NOB.CR	$1,060.50
D6060	ABUT.SUPPORT.PORCE.METAL CROWN	$960.75
D6061	ABUT.SUPPORT.PORC.NOBLE.MTL.CR	$1,031.10
D6062	ABUT.SUPPORT.CAST HIGH NOB.CRN	$1,001.70
D6063	ABUT.SUPPORT.CAST METAL CROWN	$867.30
D6064	ABUT.SUPPORT.CAST NOBLE MTL.CR	$935.55
D6065	IMPLANT SUPPORT.PORCE/CERAM.CR	$1,080.45
D6066	IMPLANT SUPPORT.PORCE.METAL CR	$1,060.50
D6067	IMPLANT SUPPORTED METAL CROWN	$1,001.70
D6068	ABUT.SUPPORT.RET.PORCE/CER.FPD	$1,080.45
D6069	ABUT.SUPP.RET.PORC.HIGH NB.RFD	$1,031.10
D6070	ABUT.SUPP.RET.PORC.METAL FPD	$931.35
D6071	ABUT.SUPP.RET.PORCE.NB.MTL.FPD	$1,003.80
D6072	ABUT.SUPPORT.RET.CAST MTL.FPD	$975.45
D6073	ABUT.SUPPORT.RET.CAST MTL.FPD	$844.20
D6074	ABUT.SUPPORT.RET.CAST MTL.FPD	$909.30
D6075	IMPLANT SUPP.RET.CERAMIC FPD	$1,052.10
D6076	IMPLANT SUPP.RET.PORCE.MTL.FPD	$1,031.10
D6077	IMPLANT SUPP.RET.CAST MTL.FPD	$975.45
D6080	IMPLANT MAINTENANCE-CLEANSING	$66.15
D6082	IMPLANT SUPPORTED CROWN-PORCE.PREDOM.	$779.00
D6083	IMPLANT SUPPORTED CROWN-PORCE.NOBLE	$779.00
D6084	IMPLANT SUPPORTED CROWN-PORCE.TITANIUM	$779.00
D6085	INTERIM IMPLANT CROWN	$93.00
D6086	IMPLANT SUPPORTED CROWN-PREDOM.BASE ALLO	$762.00
D6087	IMPLANT SUPPORTED CROWN-NOBLE ALLOYS	$762.00
D6088	IMPLANT SUPPORTED CROWN-TITANIUM	$762.00
D6090	REPAIR IMPLANT SUPPORT.PROSTHE	$190.05
D6091	REPL.ATTACH.IMPLANT SUPP.PROS.	$350.70
D6092	RECEMENT IMPLANT SUPPORT.BRDGE	$52.50
D6093	RECEMENT IMPLANT SUPPORT.BRDGE	$89.25
D6094	ABUT.SUPPORTED CROWN-TITANIUM	$975.45
D6095	REPAIR IMPLANT ABUTMENT	$468.00
D6096	REMOVE BROKEN IMPLANT RETAINING SCREW	$174.00
D6097	ABUTMENT SUPPORTED CROWN-PORCE.TITANIUM	$727.00
D6098	IMPLANT SUPPORTED RETAINER-PORCE.PREDOM.	$727.00
D6099	IMPLANT SUPPORTED RETAINER FOR FPD-PORCE	$802.00

D6100	IMPLANT REMOVAL	$325.45
D6101	DEBRIDEMENT PERI-IMPLANT DEFECT/SURFACES	$260.00
D6102	DEBRIDEMENT/OSSEOUS CONTOURING PERI-IMPL	$260.00
D6103	BONE GRAFT FOR REPAIR PERI-IMPLANT DEFEC	$425.00
D6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	$425.00
D6110	IMPLANT/ABUTMENT SUPPORTED DENTURE-MAX.	$1,355.55
D6111	IMPLANT/ABUTMENT SUPPORTED DENTURE-MAND.	$1,355.55
D6112	IMPLANT/ABUT.SUPPORTED RMVBLE DNT-MAX	$1,257.90
D6113	IMPLANT/ABUT.SUPPORTED RMVBL DNT-MAND	$1,257.90
D6114	IMPLANT/ABUT.SUPPORTED DENTURE-EDEN-MAX	$1,355.55
D6115	IMPLANT/ABUT SUPPORTED FIXED DENTURE-MND	$1,355.55
D6116	IMPLANT/ABUT.SUPPORT FIXED DENTURE-MAX	$1,450.05
D6117	IMPLANT/ABUT.SUPPORT.FIXED DENTURE-MAND	$1,450.05
D6120	IMPLANT SUPPORTED RETAINER-PORCE.TITANIU	$727.00
D6121	IMPLANT SUPPORTED RETAINER FOR METAL FPD	$636.00
D6122	IMPLANT SUPPORTED RETAINER-METAL FPD-NOB	$782.00
D6123	IMPLANT SUPPORTED RETAINER-FPD-TITANIUM	$636.00
D6190	RADIOGRAPHIC/SURG.IMPLANT INDE	$158.00
D6191	SEMI-PRECISION ABUTMENT-PLACEMENT	$345.00
D6192	SEMI-PRECISION ATTACHMENT-PLACEMENT	$345.00
D6194	ABUT.SUPPORT.RET.CR.FPD.TITANI	$929.00
D6195	ABUTMENT SUPPORTED RETAINER-PORCE.TITANI	$727.00
D6198	REMOVE INTERIM IMPLANT COMPONENT	$43.00
D6205	PONTIC-INDIRECT RESIN COMPOSIT	$692.00
D6210	PONTIC-CAST HIGH NOBLE METAL	$847.00
D6211	PONTIC-CAST PREDOM.BASE METAL	$680.00
D6212	PONTIC-CAST NOBLE METAL	$782.00
D6214	PONTIC-TITANIUM	$745.00
D6240	PONTIC-PORCELAIN HIGH NOBLE	$866.00
D6241	PONTIC-PORCELAIN PREDOM. BASE	$753.00
D6242	PONTIC-PORCELAIN NOBLE METAL	$802.00
D6243	PONTIC-PORCE.TITANIUM/TITANIUM ALLOYS	$727.00
D6245	PONTIC-PORCE/CERAMIC-MARYLAND	$847.00
D6250	PONTIC-RESIN HIGH NOBLE METAL	$842.00
D6251	PONTIC-RESIN PREDOM.BASE METAL	$692.00
D6252	PONTIC-RESIN NOBLE METAL	$776.00
D6253	PROVISIONAL PONTIC	$267.00
D6545	RETAINER-MARYLAND BRIDGE ABUT	$349.00
D6548	RETAINER-PORCE/CERAMIC-RESIN	$831.00
D6549	RESIN RETAINER-RESIN FIXED PROSTHESIS	$349.00
D6600	INLAY-PORCE/CERAMIC-2 SURFACES	$782.00
D6601	INLAY-PORCE/CERAMIC-3+SURFACES	$782.00

D6602	INLAY-CAST H.N.MTL-2 SURFACES	$609.00
D6603	INLAY-CAST H.N.MTL-3+SURFACES	$705.00
D6604	INLAY-CAST PREDOM.MTL-2 SURF.	$609.00
D6605	INLAY-CAST PREDOM.MTL-3+SURF.	$705.00
D6606	INLAY-CAST NOBLE MTL-2 SURF.	$609.00
D6607	INLAY-CAST NOBLE MTL-3+SURF.	$705.00
D6608	ONLAY-PORCE/CERAMIC-2 SURFACES	$782.00
D6609	ONLAY-PORCE/CERAMIC-3+SURFACES	$804.00
D6610	ONLAY-CAST H.N.MTL-2 SURFACES	$619.00
D6611	ONLAY-CAST H.N.MTL-3+SURFACES	$722.00
D6612	ONLAY-CAST PREDOM.MTL-2 SURF.	$619.00
D6613	ONLAY-CAST PREDOM.MTL-3+SURF.	$722.00
D6614	ONLAY-CAST NOBLE METAL-2 SURF.	$619.00
D6615	ONLAY-CAST NOBLE METAL-3+SURF.	$722.00
D6624	INLAY-TITANIUM	$555.00
D6634	ONLAY-TITANIUM	$619.00
D6710	CROWN-INDIRECT RESIN COMPOSITE	$576.00
D6720	ABUTMENT-RESIN HIGH NOBLE MTL	$847.00
D6721	CROWN-RESIN PREDOM.BASE METAL	$741.00
D6722	CROWN-RESIN NOBLE METAL	$796.00
D6740	ABUTMENT-PORCELAIN/CERAMIC	$847.00
D6750	CROWN-PORCELAIN HIGH NOBLE MTL	$866.00
D6751	CROWN-PORCELAIN PREDOM.BASE	$760.00
D6752	ABUTMENT-PORCELAIN NOBLE METAL	$831.00
D6753	RETAINER-CROWN-PORCE.TITAN.& TITAN.ALLOY	$760.00
D6780	CROWN-3/4 CAST HIGH NOBLE MTL.	$799.00
D6781	CROWN-3/4 CAST PREDOM.BASE MTL	$799.00
D6782	CROWN-3/4 CAST NOBLE METAL	$799.00
D6783	CROWN-3/4 PORCELAIN/CERAMIC	$831.00
D6784	RETAINER CROWN-3/4 TITANIUM/TITAN.ALLOYS	$799.00
D6790	ABUTMENT-FULL CAST HIGH NOBLE	$866.00
D6791	CROWN-FULL CAST PREDOM.BASE	$799.00
D6792	CROWN-FULL CAST NOBLE METAL	$799.00
D6793	PROVISIONAL RETAINER CROWN	$267.00
D6794	CROWN-TITANIUM	$745.00
D6920	CONNECTOR BAR	$525.00
D6930	RECEMENT FIXED PARTIAL DENTURE	$87.00
D6940	STRESS BREAKER	$264.00
D6950	PRECISION ATTACHMENT	$334.00
D6980	FIXED PARTIAL DENTURE REPAIR	$195.00
D6985	PEDIATRIC PARTIAL DENTURE-FIXED	$195.00
D7111	CORONAL REMNANTS-DECIDUOUS TTH	$130.00

D7140	EXTRACTION-ERUPTED TTH,EXPOSED	$150.00
D7210	SURGICAL REMOVAL ERUPTED TOOTH	$350.00
D7220	REMOVAL ERUPTED TTH-SOFT TISS	$400.00
D7230	REMOVAL ERUPTED TTH-PRTL BONY	$425.00
D7240	REMOVAL ERUPTED TTH-FULL BONY	$475.00
D7241	RMVL.IMPACT-FULL BONY-UNUSUAL	$509.00
D7250	SURGICAL RMVL.RESIDUAL TH ROOT	$215.00
D7251	CORONECTOMY-INTENTIONAL PRTL TTH RMVL	$462.00
D7260	OROANTRAL FISTULA CLOSURE	$835.00
D7261	PRIMARY CLOSURE SINUS PERFORAT	$835.00
D7270	TOOTH REIMPLANTATION	$499.00
D7272	TOOTH TRANSPLANTATION	$575.00
D7280	SURG.ACCESS OF UNERUPTED TOOTH	$409.00
D7282	MOBILIZATION ERUPT/MALPOS.TTH	$452.00
D7283	PLACEMENT OF DEVICE ERUPTED IMPACTED TTH	$205.00
D7285	BIOPSY OF ORAL TISSUE-HARD	$375.00
D7286	BIOPSY OF ORAL TISSUE-SOFT	$325.00
D7287	CYTOLOGY SAMPLE COLLECTION	$61.00
D7288	BRUSH BIOPSY-TRANSEPITHELIAL	$61.00
D7290	SURGICAL REPOSITIONING OF TTH	$311.00
D7291	TRANSSEPTAL FIBEROTOMY	$85.00
D7292	SURG.PLCMT.TEMP.ANCHORAGE DEVI	$1,422.00
D7293	SURG.PLCMT.TEMP.ANCHORAGE-FLAP	$1,067.00
D7294	PLCMNT.TEMP.ANCHOR.W/OUT FLAP	$889.00
D7296	CORTICOTOMY-1-3 TTH/TTH SPACES-PER QUAD	$129.00
D7297	CORTICOTOMY-4+TTH/TOOTH SPACES-PER QUAD	$209.00
D7298	REMOVAL OF TEMPORARY ANCHORAGE DEVICE	$820.00
D7299	REMOVAL OF TEMPORARY ANCHORAGE,W/FLAP	$656.00
D7300	REMOVAL OF TEMPORARY ANCHORAGE W/O-FLAP	$547.00
D7310	ALVEOLOPLASTY W/EXT-PER QUAD	$209.00
D7311	ALVEOLOPLASTY W/EXT-1-3 TEETH	$129.00
D7320	ALVEOLOPLASTY W/OUT EXT-QUAD	$340.00
D7321	ALVEOLOPLASTY-W/OUT EXT-1-3 TH	$204.00
D7340	VESTIBULOPLASTY	$796.00
D7350	VESTIBULOPLASTY-INC.TISS.GRFTS	$2,136.00
D7410	EXCISION BENIGN LESION<1.25 CM	$121.00
D7411	EXCISION BENIGN LESION>1.25 CM	$392.00
D7412	EXCISION BENIGN LESION-COMPLIC	$243.00
D7440	EXCISION MALIGNANT TUMOR<1.25	$414.00
D7441	EXCISION MALIGNANT TUMOR>1.25	$656.00
D7450	RMVL ODONTO.CYST/TUMOR <1.25CM	$311.00
D7451	RMVL ODONTO.CYST/TUMOR >1.25CM	$724.00

D7460	RMVL NONODONTO CYST/TUMOR<1.25	$387.00
D7461	RMVL NONODONTO CYST/TUMOR>1.25	$460.00
D7465	DESTRUCTION OF LESIONS,BY RPRT	$400.00
D7471	REMOVAL OF EXOSTOSIS-PER SITE	$484.00
D7472	REMOVAL OF TORUS PALATINUS	$484.00
D7473	REMOVAL OF TORUS MANDIBULARIS	$484.00
D7485	SURG.REDUCTION OSSEOUS TUBEROS	$484.00
D7510	INCISION & DRAINAGE-INTRAORAL	$134.00
D7511	INCISION & DRAINAGE-INTRAORAL,COMPLICATE	$161.00
D7520	INCISION & DRAIANGE-EXTRAORAL	$200.00
D7521	INCISION & DRAINAGE-EXTRAORAL,COMPLICATE	$200.00
D7530	REMOVE FOREIGN BODY-SOFT TISS	$204.00
D7540	REMOVE FOREIGN BODY FROM BONE	$446.00
D7550	SEQUESTRECTOMY/PRTL OSTECTOMY	$513.00
D7560	MAXILLARY SINUSOTOMY	$446.00
D7610	FRACTURE-SIMPLE-MAX-OPEN RED	$1,423.00
D7620	FRACTURE-SIMPLE-MAX-CLOSED	$1,168.00
D7630	FRACTURE-SIMPLE-MAND-OPEN RED	$2,300.00
D7640	SIMPLE FRACTURE-MAND-CLOSED	$1,811.00
D7650	FRACTURE-SIMPLE-MALAR/ZYG-OPEN	$1,198.00
D7660	FRACTURE-SIMPLE-MALAR/ZYG-CLOS	$787.00
D7670	FRACTURE-SIMPLE-ALVEOLUS	$1,091.00
D7671	ALVEOLUS-OPEN RED/STABILIZATIO	$1,091.00
D7680	FACIAL BONES-COMPLICATED RED	$1,597.00
D7710	FRACTURE-COMPOUND-MAX-OPEN RED	$1,432.00
D7720	FRACTURE-COMPOUND-MAX-CLOSED	$1,065.00
D7730	FRACTURE-COMPOUND-MAND-OPEN	$1,997.00
D7740	FRACTURE-COMPOUND-MAND-CLOSED	$1,814.00
D7750	FRACT-COMPOUND-MALAR/ZYG-OPEN	$1,198.00
D7760	FRACT-COMPOUND-MALAR/ZYG-CLOSE	$666.00
D7770	FRACTURE-COMPOUND-ALVEOLUS	$1,092.00
D7771	ALVEOLUS-CLOSED RED.STABILIZAT	$1,092.00
D7780	COMPOUND FACIAL BONES-COMPLICATED	$1,165.00
D7810	OPEN REDUCTION OF DISLOCATION	$503.00
D7820	CLOSED REDUCTION-DISLOCATION	$314.00
D7830	MANIPULATION UNDER ANESTHESIA	$363.00
D7840	CONDYLECTOMY	$666.00
D7850	SURG.DISCECTOMY-W/OR W/OUT IMP	$900.00
D7871	NON-ARTHROSCOPIC LYSIS/LAVAGE	$90.00
D7880	OCCLUSAL ORTHOTIC DEVICE	$555.00
D7881	OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT	$53.00
D7910	SUTURE OF RECENT SMALL WOUND	$261.00

D7911	COMPLICATED SUTURE < 5CM	$345.00
D7912	COMPLICATED SUTURE > 5CM	$377.00
D7921	COLLECTION/APPLICATION AUTOLOGOUS BLOOD	$65.00
D7950	OSSEOUS/OSTEOP.CARTILAGE GRFT.	$900.00
D7951	SINUS AUGMENT.BONE SUBSTITUTES	$711.00
D7952	SINUS AUGMENTATION VIA VERTICAL APPROACH	$433.00
D7953	BONE REPLACE.GRFT.RIDGE PRESER	$380.00
D7955	REPAIR MAXILLOFAC.SOFT/HARD TI	$687.00
D7961	BUCCAL/LABIAL FRENECTOMY(FRENULECTOMY)	$311.00
D7962	LINGUAL FRENECTOMY(FRENULECTOMY)	$311.00
D7963	FRENULOPLASTY	$311.00
D7970	EXCISION HYPERPLASTIC TIS-ARCH	$327.00
D7971	EXCISION PERICORONAL GINGIVA	$144.00
D7972	SURG.REDUCTION FIBROUS TUBEROS	$484.00
D7979	NON-SURGICAL SIALOLITHOTOMY	$302.00
D7980	SIALOLITHOTOMY	$604.00
D7983	CLOSURE OF SALIVARY FISTULA	$201.00
D7990	EMERGENCY TRACHEOTOMY	$278.00
D7994	SURGICAL PLACEMENT: ZYGOMATIC IMPLANT	$1,500.00
D7998	PLCMT FIXATION DEVICE-NO FRACT	$1,422.00
D8010	LIMITED ORTHO TRMT-PRIMARY	$700.00
D8020	LIMITED ORTHO TRT-TRANSITIONAL	$700.00
D8030	LIMITED ORTHO TRMNT-ADOLESCENT	$700.00
D8040	LIMITED ORTHO TREATMENT-ADULT	$700.00
D8050	INTERCEPTIVE ORTHO TX-PRIMARY DENTITION	$800.00
D8060	INTERCEPTIVE ORTHO TX-TRANSITIONAL DENT.	$800.00
D8070	COMPREHENSIVE TRT-TRANSITIONAL	$800.00
D8080	COMPREHENSIVE TRMT-ADOLESCENT	$800.00
D8090	COMPREHENSIVE ORTHO TRMT-ADULT	$800.00
D8210	ORTHO-REMOVABLE APPLIANCE	$700.00
D8220	FIXED APPLIANCE THERAPY	$147.00
D8660	PRE-ORTHODONTIC TRMNT.VISIT	$200.00
D8670	ORTHO TX-QUARTERLY-UP TO LIFETIME MAX	$862.00
D8680	RETENTION-INCLUDES RETAINER FEES.	$357.00
D8696	REPAIR OF ORTHODONTIC APPLIANCE-MAX.	$83.00
D8697	REPAIR OF ORTHODONTIC APPLIANCE-MAND.	$83.00
D8698	RE-CEMENT OR RE-BOND FIXED RETAINER-MAX	$42.00
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER-MAND	$42.00
D8703	REPLACEMENT OF LOST/BROKEN RETAINER-MAX	$357.00
D8704	REPLACEMENT OF LOST/BROKEN RETAINER MAND	$357.00
D9110	PALLIATIVE TREATMENT	$76.00
D9120	FIXED PARTIAL DENTURE SECTIONING	$195.00

D9210	LOCAL ANESTHESIA	$21.00
D9211	REGIONAL BLOCK ANESTHESIA	$21.00
D9212	TRIGEMINAL DIV.BLOCK ANESTH.	$20.00
D9222	DEEP SEDATION/GEN.ANESTHESIA-1ST.15 MINS	$119.66
D9223	DEEP SEDATION/GENERAL ANESTHESIA-15 MINS	$119.66
D9230	ANALGESIA,ANXIOLYSIS-NITROUS	$45.00
D9239	IV SEDATION/ANALGESIA-FIRST 15 MINUTES	$120.00
D9243	IV SEDATION/ANALGESIA-EACH 15 MINUTES	$120.00
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	$33.00
D9310	CONSULTATION BY SPECIALIST	$107.00
D9410	HOUSE/EXTENDED CARE CALL	$63.00
D9420	HOSPITAL CALL	$206.00
D9430	OFFICE VISIT-DURING REG HOURS	$43.00
D9440	OFFICE VISIT-AFTER REG HOURS	$58.00
D9450	CASE PRESENTATION-DETAILED/EXT	$30.00
D9610	THERAPEUTIC DRUG INJECTION	$43.00
D9612	THERAPEUTIC PARENTAL DRUGS-2+	$75.00
D9630	OTHER DRUGS/MEDICAMENTS	$32.00
D9910	APP.DESENSITIZING MEDICAMENT	$35.00
D9911	APP.OF DESENSITIZING RESIN	$35.00
D9920	BEHAVIOR MANAGEMENT,BY REPORT	$39.00
D9930	TREATMENT OF COMPLICATIONS	$65.00
D9941	FABRICATION ATHLETIC MOUTHGUARD	$106.00
D9943	OCCLUSAL GUARD ADJUSTMENT	$53.00
D9944	OCCLUSAL GUARD-HARD APPLIANCE,FULL ARCH	$426.00
D9945	OCCLUSAL GUARD-SOFT APPLIANCE,FULL ARCH	$426.00
D9946	OCCLUSAL GUARD-HARD APPLIANCE,PRTL ARCH	$426.00
D9950	OCCLUSION ANALYSIS-MOUNTED CAS	$124.00
D9951	OCCLUSAL ADJUSTMENT-LIMITED	$78.00
D9952	OCCLUSAL ADJUSTMENT-COMPLETE	$299.00
D9970	ENAMEL MICROABRASION	$41.00
D9971	ODONTOPLASTY 1-2 TEETH	$42.00
D9972	EXTERNAL BLEACHING-PER ARCH	$256.00
D9973	EXTERNAL BLEACHING-PER TOOTH	$70.00
D9974	INTERNAL BLEACHING-PER TOOTH	$194.00

ORTHODONTIC SERVICES

The Fund will pay up to $1,250.00 per quarter, and up to a maximum of $5,000.00 lifetime, for all approved orthodontic procedures and appliances performed on Dependent children that commence between ages eight and nineteen inclusive. The lifetime and quarterly maximums do not apply to orthodontic services that are considered essential health benefits in New York (e.g., cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.)

PRESCRIPTION DRUG BENEFIT

The Fund's prescription drug benefit program is administered by Maxor Plus. Subject to the provisions of this Section and other applicable limitations and exclusions described in this document, the Fund will cover the cost of prescription drugs provided by a pharmacy in the Maxor Plus network at 100%.

You can fill your prescription at any retail pharmacy that participates in Maxor's pharmacy network. To locate a participating pharmacy in your area, you can log onto Maxor's website at www.maxor.com/maxorplus or contact Maxor's Member Services help desk at 1-800-687-0707. The Fund will not cover the cost of any prescription that is filled at a pharmacy that does not participate in the Maxor pharmacy network so please make sure you verify that your pharmacy participates in this network.

In order to receive coverage for your prescription, make sure to provide your pharmacy with a copy of your prescription drug card that lists Maxor as your prescription drug provider. If you fail to provide your card at the time your prescription is filled, the pharmacy may charge you for the full cost of the prescription and any subsequent reimbursement from the Fund will be limited to the amount the Fund would have paid for that prescription under its arrangement with Maxor, even if you paid more for the prescription.

Medications that are not included in the Fund's formulary are excluded from Fund coverage under the Plan. If you have questions regarding whether a medication is covered, please contact Maxor at 1-800-687-0707.

Quantity Limitations, Pre-authorizations, Step Therapy, and Other Limitations

Prior Authorizations

Certain drugs and drug classifications require prior authorization before the Fund will cover that drug. Prior authorization helps to ensure that the prescribed drug is the most appropriate medication to treat your condition. All prior authorizations will be reviewed by a clinical pharmacist at Maxor based on pre-established medical criteria and follow-up with the prescriber. The following claims are subject to prior authorization:

- Any drug that exceeds $500 for a 30-day supply;
- Any drug that exceeds $1,500 for a 31-90 supply;
- Compound medications that exceed $250;
- Drugs designated by Maxor to be subject to prior authorization;
- Replacements for lost or stolen medications; and
- Requests for an additional supply because of travel.

If you are taking a prescription that requires prior authorization, Maxor will automatically address that at the time your claim is submitted by the pharmacy. If your claim is denied based on the prior authorization review, you will be notified of that determination and you can appeal that determination to the Fund's Board of Trustees pursuant to the claims and appeals rules described beginning on page 78 of the SPD.

Quantity Limits

Quantity limits are placed on certain medications to ensure effectiveness, safety, and appropriate usage of the medication. The quantity limit is the maximum amount of a particular medication that can be provided to a Covered Person during a given amount of time. If a medication is prescribed over the standard maximum limit for that drug, a prior authorization will need to be completed. If the prior authorization is denied, the Fund will only cover the prescription up to the maximum quantity limit for that medication. For a list of drugs that are subject to quantity limits, please contact Maxor.

Step Therapy

Step therapy is a process used to ensure that the most effective, safe, and least costly medications are tried first before moving on to other medications. If you submit a prescription for a drug that is subject to Maxor's step therapy program, a Maxor clinician will contact the prescriber to determine if there is a medical reason that you cannot take a drug on a "lower step" than the one prescribed. If the prescriber agrees, your prescription will be filled consistent with the Fund's step therapy program. If you have any questions about whether a particular drug is subject to a step therapy program or how that program works, please contact Maxor.

Other Limitations

Many brand drugs have a generic equivalent that is required to have the same quality, strength, and purity as the brand drug. Therefore, if you receive a prescription for a brand drug that has a generic equivalent, the pharmacist will fill the prescription using the generic equivalent. If you request that the brand drug be provided instead, the Fund will cover the cost of the brand drug up to the amount it would cover for the generic equivalent and you will be required to pay the

difference, in addition to the applicable Co-payment, unless the prescriber requires that you receive the brand drug, in which case the Fund will cover the brand drug subject to the other requirements of this Section.

Mail Order Services

You can, but are not required to, refill prescriptions for maintenance drugs through the Fund's mail order pharmacy. Through the mail order service, you will receive a 90-day supply at no cost to you and the medication will be shipped directly to the address you choose. If you wish to refill your maintenance drug prescription by mail, please contact Maxor. It is recommended that you have your physician write an updated prescription of your medication so that you can send it to Maxor. However, if you are unable to obtain an updated prescription, you can have your refills transferred to Maxor by contacting Maxor at (800) 687-8629 and providing your previous mail service pharmacy information. Additional information can be found online at www.maxor.com/maxorplus.

Alternatively, if you would prefer not to use mail order, after you have filled a 30-day prescription for a maintenance drug at a retail pharmacy, you can then receive a 90-supply at retail also at no cost to you.

Immunizations

Participants are eligible to receive the following vaccinations with no out-of-pocket costs at any participating pharmacy – seasonable influenza, pneumococcal, acute herpes zoster (shingles), hepatitis A&B, HPV, measles, mumps, rubella, varicella, meningococcal, tetanus, diphtheria and pertussis. Coverage is limited as follows:

- To covered individuals ages 18 and older pursuant to a patient specific order signed by a New York State licensed physician or nurse practitioner ("Order"), except for the seasonable influenza vaccination, which applies to covered individuals ages two and older pursuant to an Order; or

- Without an Order for individuals ages two and older for the seasonable influenza vaccination and 18 and older for all other covered vaccinations, only in accordance with the most current Advisory Committee for Immunization Practices (ACIP), which may include additional age restrictions.

The Fund will also cover the cost of any immunization intended to prevent or mitigate the coronavirus (COVID-19) disease that has received either (i) a recommendation from the U.S. Preventive Services Task Force or (ii) a recommendation from the Advisory Committee on Immunization Practice, which has been approved by the CDC. ("Coronavirus Vaccine"). The Plan will cover the cost of administering Coronavirus Vaccine at 100% of the negotiated rate with participating pharmacies.

Limitations and Exclusions

In addition to the limitation described in this Section and the Limitations and Exclusions applicable to all forms of benefits, no benefits are payable for the following:

- Drugs used for cosmetic purposes, except that injectables (e.g., Botox) will be covered if medically necessary based on a prior authorization review;
- Depigmentation products used for conditions requiring bleaching agent;
- Non-oral contraceptives, with the exception of NuvaRing, Ortho Evra and Depo-Provera;
- Drugs used to treat impotence;
- Weight management drugs;
- Any immunization administered at a pharmacy that is not otherwise specifically included in coverage as described in this Section;
- Vitamins other than prenatal vitamins, except to the extent considered preventative care under applicable law;
- Fluoride products;
- Nicotine and Nicorette Transdermal Systems;
- Insulin pumps and related supplies;
- Allergy Serums;
- Unauthorized refills;
- Items lawfully obtainable without prescription;
- Any charge for the administration of a drug or insulin;
- Medication for a Covered Person confined to a rest home, nursing home, sanitarium, extended care facility, Hospital or similar entity; except with respect to the administration of a Coronavirus Vaccine, to the extent consistent with the coverage terms described in this SPD;
- Any charge above the Customary, advertised or posted charge, whichever is less than the scheduled amounts;
- Devices and Appliances;
- Investigational or Experimental drugs, except as otherwise required by law;
- Immune altering drugs;
- Prescriptions covered without charge under Federal, State or Local programs, to include

Worker's Compensation;

- Drugs not approved during the prior authorization process;
- Fertility drugs in excess of three rounds of IVF.

DEATH BENEFIT

In the event of the death of a Participant, the death benefit shown in the Schedule of Benefits will be paid to the deceased person's beneficiary pursuant to an insurance contract issued by the Hartford Life Insurance Company.

It is very important that you designate the individual (beneficiary) to whom you wish your death benefit to be paid. You may name anyone you wish as your beneficiary and you may change your beneficiary designation as often as you like by completing the proper forms. These forms can be obtained by contacting the Fund Office. In the event that your beneficiary dies before you, the benefit will be paid pursuant to the provisions of the Policy.

Please refer to the booklet prepared by the Hartford Life Insurance Company for more details regarding this benefit. If there are any inconsistencies between the terms of this Plan and the Hartford Life Insurance Company booklet, the booklet will always control.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

In the event of the accidental death of a Participant, or in the event a Participant sustains a purely accidental loss, the benefit payments will be provided through an insurance contract with the Hartford Life Insurance Company. Please refer to the booklet prepared by the Hartford Life Insurance for more details regarding this benefit.

SHORT TERM DISABILITY BENEFITS

In the event that you become disabled from a covered accident, Sickness, or pregnancy, you may be eligible for short-term income protection, as shown in the Schedule of Benefits. This benefit is provided through an insurance contract issued by the Hartford Life Insurance Company. Please refer to the booklet prepared by the Hartford Life Insurance Company for more details regarding this benefit.

COBRA CONTINUATION COVERAGE

History of COBRA

On April 7, 1986 a Federal law was enacted (Public Law 99-272, Title X), called the Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, allowing Participants and their Dependents to contribute to a temporary extension of health coverage (called "Continuation Coverage") at group rates in certain instances where coverage under the Welfare Plan would otherwise end.

Qualifying Events

If any of the following events ("Qualifying Event") result in loss of benefits, the appropriate Covered Person will be offered the opportunity for a temporary continuation of benefits coverage at group rates, so long as the person was covered under the Plan on the day before the Qualifying Event:

(a) Participant's termination of employment, for reasons other than gross misconduct;

(b) Participant's reduction in hours of employment;

(c) Participant's entitlement to Medicare;

(d) Death of the Participant;

(e) Participant's divorce;

(f) Participant's legal separation;

(g) Loss of eligibility by a Dependent child.

An increase in premiums or contributions that must be paid by the Employee as a result of any of the above-listed events constitutes a loss of coverage and entitles the Covered Person to continuation coverage under COBRA.

Reporting Requirements

The Participant's Employer must notify the Fund Office of the occurrence of any of the following qualifying events regarding the Participant: termination of employment; reduction of working hours to less than twenty (20) hours per week; entitlement to Medicare; death of the Participant. This notification must be in writing and must be furnished within thirty (30) days of the occurrence of the qualifying event. Failure to provide such timely notification may subject the employer to serious Federal tax sanctions.

The affected Covered Person must notify the Fund Office in the event of divorce or legal separation from the Participant or loss of eligibility by a Dependent child. This notification must be furnished in writing within sixty (60) days of the occurrence of the qualifying event. Failure to furnish such notification within the required sixty (60) days may result in the loss of the right to Continuation Coverage.

Reporting of Second Qualifying Event or Disability

Participants and Dependents covered under COBRA Continuation Coverage must provide written notice of a second Qualifying Event or Disability to the Fund Office within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA Continuation Coverage period. The written notice must conform to the requirements for providing notices in the section titled "Content of Notice." The notice must include evidence of the second Qualifying Event or disability (for example a copy of the: divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, Dependent's birth

certificate, SSA disability determination).

Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give proper notice within sixty (60) days of the date of the Qualifying Event for which the Covered Person is responsible to give notice (see below), or a Contributing Employer within thirty (30) days of the Qualifying Event for which the contributing Employer is required to give notice (see below) and, as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect continuation coverage under this provision, then the Covered Person or the Contributing Employer, as appropriate, shall be obligated to reimburse the Plan for any claims that should not have been paid. If a Covered Person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual and his or her Dependents.

If a Contributing Employer fails to give proper notice within thirty days of the Qualifying Event as required and the Covered Person is, as a result, permitted to elect, and does elect Continuation Coverage more than ninety (90) days after the date of the Qualifying Event, the Employer shall be obligated to reimburse the Plan for all claims paid by the Plan on behalf of the Covered Person. The Trustees, in their sole discretion, may limit the application of this subsection where it appears, based on all circumstances, that the Covered Person would have elected Continuation Coverage within ninety days of the Qualifying Event had notice of the right to such an election been provided during the period.

In addition, a Participant or eligible Dependent must notify the Fund Office immediately if the Participant and/or Dependent become covered by any other plan of group health benefits whether through employment or otherwise. The Fund must be repaid for any claims paid in error as a result of a failure to notify the Fund Office of any other health coverage.

Notice and Election Form

The Fund Office will, within ninety (90) days of the date a Participant or Dependent first becomes covered under the Fund, send a general notice regarding COBRA rights.

Participants and Dependents are required to notify the Fund Office in the event that they experience one of the following qualifying events:

(a) divorce or legal separation;

(b) a Dependent losing eligibility for coverage under the Fund; or

(c) the occurrence of a disability or a second qualifying event after becoming entitled to COBRA coverage.

The Participant or Dependent is required to notify the Fund Office within sixty (60) days of the later of the occurrence of a Qualifying Event described above or the date on which there is a loss of coverage as a result of the event. If a qualified beneficiary receives notice of disability determination by the Social Security Administration, the qualified beneficiary must give notice to the Fund Office of such determination within sixty (60) days of the later of the date the Social

Security determination, the date on which the qualified beneficiary is informed of the obligation to provide notice of disability, or the date on which the qualified beneficiary loses or would lose coverage.

Notice to the Fund Office of a qualifying event is properly made when the Participant or Dependent writes to the Fund Office and indicates (1) the name of the Participant and/or Dependent who should be covered, (2) a description of the Qualifying Event, and (3) the date of the Qualifying Event. The Notice should also include any relevant documentary support.

Employers are responsible for sending the Fund Office notice in the event that an Employee experiences one of the following Qualifying Events:

(a) termination of employment;

(b) reduction in hours of employment;

(c) death of an Employee; or

(d) an Employee becomes entitled to Medicare.

The Fund Office will send within fourteen (14) days of the receipt of notification of the occurrence of a Qualifying Event, a COBRA Notice and Election Form. This form will describe the coverage options available, their costs and the conditions under which the Continuation Coverage will terminate. The Fund Office will also send a potential Covered Person who is <u>not</u> entitled to receive COBRA coverage, notice that they will not be covered within fourteen (14) days after the occurrence of a purported qualifying event. This notice will describe why COBRA coverage is not available.

In order to obtain Continuation Coverage under the provisions of COBRA, the Notice of Election Form must be completed and returned to the Fund Office within sixty (60) days after receipt. Payment of the COBRA premium, retroactive to the date on which coverage under the Plan terminated, must be made within forty-five (45) days after the return of the completed COBRA Notice and Election Form.

If the Covered Person qualifies for continued coverage under COBRA and elects to waive the coverage during the election period, the person may later elect COBRA coverage if done so before the end of the election period. However, if the coverage is initially waived and the waiver is later revoked during the election period, the plan is not required to provide coverage retroactively and is only required to provide coverage prospectively from the date the waiver is revoked.

Content of Notice

The written notice of a Qualifying Event or Second Qualifying Event must include the following information: name and address of affected Participant and or Dependent, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example: a copy of the divorce decree, separation agreement, death certificate, Dependent's birth

certificate, Dependent's adoption records). Once the Fund receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and Dependents, as applicable.

Notice of Change of Participant’s and Dependent’s Address

It is very important that Participants and Dependents keep the Fund informed of their current addresses. If you or a covered family member experience a change of address, immediately inform the Fund Office.

Spousal Rights

So long as the Dependent spouse of the Participant was covered under the Plan on the day before the Qualifying Event, the spouse will have the right to elect Continuation Coverage for himself or herself, if he or she loses coverage under the Plan for any of the following reasons:

1. the death of the Participant;

2. termination of the Participant’s employment, other than for gross misconduct, or reduction in the Participant’s hours of employment;

3. divorce or legal separation of the Participant; or

4. eligibility of the Participant for Medicare.

Dependent Children’s Rights

The Dependent child of a Participant who was covered under the Plan on the day before the Qualifying Event will have the right to choose Continuation Coverage for himself or herself, if he or she loses coverage under the Plan for any of the below listed reasons. A child who is born to or adopted by an Employee during the period of COBRA coverage is also a qualified Dependent child.

1. the death of the Participant;

2. termination of the Participant’s employment, other than gross misconduct, or reduction in the eligible person’s hours of employment;

3. divorce or legal separation of the Participant;

4. eligibility of the Participant for Medicare; or

5. the Dependent child’s ceasing to satisfy the Plan’s definition of a Dependent.

Newborn or Adopted Children

If you have a child born, or if a child is placed for adoption with you, during a period of COBRA coverage, you may elect COBRA continuation coverage for that child for the remainder of your

COBRA coverage period provided you enroll the child in accordance with the Plan's rules. Coverage for the newborn or adopted child will continue for the same time as coverage for Dependent children who were properly enrolled in the Fund on the day before the Qualifying Event. Newborn or adopted children added to your COBRA coverage also become qualified Dependents.

Premium Payments and Deductibles

Continuation Coverage requires timely application for coverage and the timely payment of premiums. The premium due date for premiums subsequent to the initial premium is the first day of the month for which Continuation Coverage is sought. For example, premiums for the month of November must be paid on or before November 1. The initial premium due for the initial period of Continuation Coverage will include payment for the period of time dating back to the date on which Plan coverage terminated. Failure to pay the full premium by each due date (or within the thirty [30] day grace period thereafter, except that for the first month of COBRA, the grace period is forty-five [45] days) will result in a loss of all Continuation Coverage. A payment will be considered timely if it is postmarked no later than the due date.

Once a timely election of Continuation Coverage has been made, it is the responsibility of you and/or your Dependent(s) seeking Continuation Coverage to make timely payment of all required premiums. The Fund will not notify you and/or your Dependent(s) that a premium payment is due or is late. Further, the Fund will not notify you/or your Dependent(s) that Continuation Coverage is about to be, or has been, terminated due to the untimely payment of a required premium.

When a Qualifying Event, such as a divorce, causes a family to split into two units, then for purposes of calculating any applicable family (as opposed to individual) Deductible, each family unit is credited with the Expenses incurred by the members in that particular family unit who have elected COBRA coverage.

COBRA Continuation Period

Coverage may continue, on a self-pay basis, as follows:

(a) Coverage for you and/or your Dependent(s) may be continued for up to eighteen (18) months, if coverage terminated due to the Participant's:

    1) termination of employment, other than for gross misconduct;

    2) reduced work hours; or

    3) retirement.

The eighteen (18) month period of Continuation Coverage starts from the date that your coverage is terminated as a result of the Qualifying Event and may be extended an additional eleven (11) months if at the time of the Qualifying Event described in (a)(1) or (a)(2) above, you or your Dependent are determined to be disabled by the Social Security Administration. Effective

January 1, 1997, this disability extension is available if you or your Dependent are determined to be disabled at any time during the first sixty (60) days of Continuation Coverage. Proof of disability must be provided to the Fund within sixty (60) days of the date the Social Security Administration makes the determination and before the end of the eighteen (18) month Continuation Coverage period. The extended period of Continuation Coverage applies to you and your other Dependents, as well as the disabled person. If the Social Security Administration determines during the initial eighteen (18) month period that the person is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines after the initial eighteen (18) month period that the person is no longer disabled, the period of Continuation Coverage ends with the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination, so long as the period of Continuation Coverage does not exceed twenty-nine (29) months.

(b) Coverage of your Dependent(s) may be continued for up to thirty-six (36) months from the date coverage terminates, if coverage terminated due to:

1) your death;

2) divorce or legal separation; or

3) with respect to your Dependent child, his or her ceasing to satisfy the Plan's definition of a Dependent.

(c) If your Dependent's coverage is continued for eighteen months as a result of a Qualifying Event listed in paragraph (a) of this section and, during the continuation period, a Qualifying Event occurs which entitles the Dependent to continue coverage under paragraph (b) of this section, your Dependent may elect to continue coverage up to a combined maximum of thirty six (36) months. If a Qualifying Event under paragraph (b) of this section occurs during the 18-month continuation period, Dependent children added to your coverage during the continuation period may also elect Continuation Coverage up to a combined maximum of thirty six (36) months. If your Dependents are covered under COBRA Continuation Coverage for 18 months because of your termination of employment or reduction in hours and you become entitled to Medicare benefits, your Medicare entitlement will not be considered a second qualifying event and your Dependents' COBRA coverage will not be extended for an additional 18-month period.

Termination of COBRA Continuation of Coverage

If you and/or your Dependent(s) do not elect Continuation Coverage, you and/or your Dependent's group health coverage will end in accordance with the plan provisions entitled "When Do Benefits Terminate?" beginning on page 14.

If you and/or your Dependent elect Continuation Coverage, the continuation coverage will cease on the ***first*** of the following dates:

(a) the date the Plan terminates;

(b) the date a required premium is due and unpaid after the applicable grace period;

(c) the date you and/or your Dependent(s) become covered under another group Health Plan as long as it is after the date you elected COBRA coverage. Contact the Fund for additional information when you and/or your Dependent(s) become covered under another group plan;

(d) the date you or your Dependent(s) first become eligible for Medicare, as long as it is after the date you elected COBRA coverage;

(e) the date the applicable period of Continuation Coverage is exhausted; or

(f) the first month that begins more than thirty (30) days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for eleven (11) months, so long as the period of Continuation Coverage does not exceed twenty nine (29) months.

(g) If your employer ceases to maintain any group Health Plan for its Employees through the Fund, the date your employer makes health coverage available to a class of Employees formerly covered under the Plan.

Details of COBRA Continuation Coverage

If you choose Continuation Coverage, the health coverage provided is identical to the health coverage provided under the Plan to similarly situated Covered Persons. If the coverage provided under the Plan is modified after you elect Continuation Coverage, your coverage will be modified accordingly.

You do not have to show that you are in good health to choose Continuation Coverage. However, under COBRA, you will have to pay the cost for your Continuation Coverage, plus a two percent (2%) administrative fee.

Trade Adjustment Assistance Act of 2002

Under the Trade Adjustment Assistance Act of 2002, certain individuals who have become unemployed as a result of imports or jobs shifted to foreign countries may be eligible for federal assistance, including a federal subsidy for COBRA coverage. In 2011, the Trade Adjustment Assistance Extension Act was passed which changed the group eligibility requirements, and individual benefits and services available under the Trade Adjustment Assistance program. Eligible Individuals must obtain a certification of Trade Act eligibility from the Department of Labor ("DOL") in order to receive Trade Act assistance and subsidies. Individuals eligible for Trade Act assistance may also have different election periods and effective dates for COBRA coverage. For more information please call the DOL's Office of Trade Adjustment Assistance toll-free 1-888-365-6822. More information about the Trade Act is also available at www.doleta.gov/tradeact. This program is offered by the federal government and the Fund Office has no role in its administration.

HIPAA PRIVACY

The Fund is required to take reasonable steps to ensure the privacy of your personally identifiable health information in accordance with the privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and the related regulations ("federal health privacy law"). In addition, the Fund must inform you about:

1. the Fund's uses and disclosures (including breaches, as described on page 66) of Protected Health Information ("PHI");
2. the Fund's duties with respect to your PHI;
3. your rights with respect to your PHI;
4. your right to file a complaint with the Fund and the Secretary of the U.S. Department of Health and Human Services;
5. the identity of the person to contact for additional information about the Fund's privacy practices.

PHI includes all individually identifiable health information that is transmitted or maintained by the Fund, or on behalf of the Fund, in connection with the Fund's provision of medical, dental, vision and pharmacy benefits, regardless of whether the information is transmitted or maintained orally, on paper or through electronic medium (such as e-mail).

Uses and Disclosures of PHI Made Without Your Consent

The Fund uses PHI to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. To the maximum extent permitted by law, the Fund may disclose your PHI to insurers, third party administrators, and health care providers for treatment, payment or other health care operations purposes. The Fund may also disclose your PHI to other third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. Under certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases, your authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

Uses and Disclosures to the Plan Sponsor

The Fund may disclose your PHI to the Trustees of the Building Trades Welfare Benefit Fund to enable the Trustees to administer the Plan. Such disclosures may be made without your authorization. The Trustees have certified that they will protect any PHI they receive in accordance with federal law.

Uses and Disclosures to Business Associates

The Fund shares PHI with its "business associates," which are third parties that assist the Fund in its operations such as preferred provider networks and prescription benefit program managers. The Fund enters into agreements with its business associates so that the privacy of your health information will be protected by them. A business associate must have any agent or subcontractor to whom the business associate provides your PHI agree to the same restrictions and conditions that apply to the business associate. The Fund is permitted to disclose PHI to its business associates for treatment, payment and health care operations without your authorization as described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

The Fund and its business associates will use and disclose PHI without your authorization for treatment, payment and health care operations as described below.

For Treatment. While the Fund does not anticipate making disclosures of PHI related to your health care treatment, if necessary, such disclosures may be made without your authorization. For example, the Fund may disclose the name of a treating specialist to your treating Physician to assist your treating Physician in obtaining records from the specialist.

For Payment. The Fund may use and disclose PHI so that your claims for health care treatment, services and supplies can be paid in accordance with the Fund's plan of benefits. For example, the Fund may tell a doctor whether you are eligible for coverage or what portion of your medical bill will be paid by the Fund.

For Health Care Operations. The Fund may use and disclose PHI to enable it to operate efficiently and can include quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, conducting or arranging for medical review, legal services and auditing functions, business planning and general administrative activities. For example, the Fund may disclose PHI to its actuaries and accountants for benefit planning purposes.

Other Uses and Disclosures That May Be Made Without Your Authorization

In addition to the uses and disclosures of PHI described above for treatment, payment or health care operations as described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization.

Required by Law. PHI may be used or disclosed for judicial and administrative proceedings pursuant to court or administrative order, legal process and authority; to report information related to victims of abuse, neglect, or domestic violence, or to assist law enforcement officials in their law enforcement duties.

Health and Safety. PHI may be disclosed to avert a serious threat to the health or safety of you or any other person. PHI also may be disclosed for public health activities, such as preventing or

controlling disease, Injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.

Government Functions. PHI may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. PHI may also be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

Active Members of the Military and Veterans. PHI may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

Workers' Compensation. PHI may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

Research. Under certain circumstances, PHI may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

Organ, Eye and Tissue Donation. If you are an organ donor, your PHI may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.

Treatment and Health Related Benefits Information. The Fund or its business associates may contact you to provide information about treatment alternatives or other health related benefits and services that may interest you, including, for example, alternative treatment, services or medication.

Deceased Individuals. The PHI of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Emergency Situations. PHI may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

Others Involved In Your Care. Under limited circumstances, your PHI may be used or disclosed to a family member, close personal friend, or others whom the Fund has verified are directly involved in your care. For example, this may occur if you are seriously injured and unable to discuss your case with the Fund. Also, upon request, the Fund may advise a family member or close personal friend about (1) your general condition, (2) your location, such as "in the Hospital," or (3) your death. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Section.

Personal Representatives. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those people who have Power of Attorney for adults.

Uses and Disclosures of PHI Pursuant to Your Authorization

Uses and disclosures of your PHI ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization at any time, provided you do so in writing. If you revoke a written authorization to use or disclose PHI, the Fund will not use or disclose your PHI, except to the extent that the Fund already relied on your authorization. Once your PHI has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your PHI may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents for unemancipated minors and those who have Power of Attorney for adults.

Unauthorized Uses and Disclosures of PHI

Under the HITECH Act, the Fund must notify you of a "Breach" of your "Unsecured PHI." "Unsecured PHI" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Department of Health and Human Services. A "Breach" of Unsecured PHI is the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information, except where an unauthorized person to whom the PHI is disclosed would not reasonably have been able to retain such information. Breach does not include:

- Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Fund if:
    - such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such Employee or individual, respectively, with the Fund; and
    - such information is not further acquired, accessed, used, or disclosed by any person
- Any inadvertent disclosure from an individual who otherwise authorized to access PHI to another similarly situated individual; and
- Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed by any person without authorization.

In the event the Plan discovers a Breach of Unsecured PHI, you will be notified if your Unsecured PHI has been, or is reasonably believed by the Plan to have been, accessed, acquired, or disclosed as a result of such Breach, in accordance with the requirements of the HITECH Act and regulations thereunder. Unless otherwise specified in HITECH Act regulations, you will receive notice of a Breach of Unsecured PHI as soon as practicable and in no case later than 60 calendar days after the discovery of the Breach. This notification applies only to any Unsecured PHI accessed, maintained, retained, modified, recorded, stored, destroyed, or otherwise held, used, or disclosed by the Plan.

Your Rights With Respect to Your PHI

You have the following rights regarding your PHI that the Fund creates, collects and maintains.

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your eligibility and coverage under the Fund's plan of benefits as well as claims and billing records. To inspect or to obtain a copy of your health record, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below. The Fund may charge a reasonable fee based on the cost for copying and mailing records associated with your request. In certain limited circumstances, the Fund may deny your request to inspect and copy your health record. This denial will be provided in writing and will set forth the reasons for the denial and will describe how you may appeal the Fund's decision.

Right to Request That Your Health Information Be Amended

You have the right to request that your PHI be amended if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed written request to the Fund's HIPAA Privacy Officer identified in this Section below. The Fund may deny your request if it is not made in writing, if it does not provide a basis in support of the request, or if you have asked to amend information that (1) was not created by or for the Fund, (2) is not part of the heath information maintained by or for the Fund, (3) is not part of the health record information that you are permitted to inspect and copy, or (4) is accurate and complete.

If the Fund denies your request, it will explain the basis for the denial in writing. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of PHI.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures by the Fund of your PHI made during the six years prior to the date of your request. However, such accounting will not include disclosures made (1) for treatment, payment or health care operations, (2) to you or authorized by you, (3) prior to February 17, 2010, (4) that were otherwise permissible under law and the Fund's privacy practices, or (5) that constitute incidental disclosures. To request an accounting of disclosures, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable fee based on the cost for each subsequent accounting. The Fund will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request that the Fund restrict the use and disclosure of your PHI. However, the Fund is not required to agree to your request for such restrictions, and the Fund may terminate a prior agreement to the restrictions you requested. To request restrictions on the use and disclosure of your PHI, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

Your request must explain what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates any agreement with respect to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your PHI be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your PHI at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the Fund's HIPAA Privacy Officer identified in this Section below.

The Fund will not retaliate or discriminate against you and no services, payment, or privileges will be withheld from you because you file a complaint with the Fund or with the Department of Health and Human Services.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Fund's HIPAA Privacy Officer identified in this Section below.

Contact Information

If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices or if you wish to exercise one of the rights described above with respect to your PHI, please contact:

HIPAA Privacy Officer
Building Trades Welfare Benefit Fund
585 Stewart Avenue, Suite 330
Garden City, New York 11530
Tel: (516) 833-9300

Changes in the Fund's Privacy Policies

The Fund reserves the right to change its privacy practices and make the new practices effective for all PHI that it maintains, including PHI that it created or received prior to the effective date of the change and PHI it may receive in the future. If the Fund materially changes any of its privacy practices, it will amend this Section and provide you with a copy of the amendment, by U.S. mail, within sixty days of the revision. In addition, copies of the amendment will be made available to you upon your written request.

COORDINATION OF BENEFITS

It is the intent of this Plan not to duplicate payments that you may be entitled to under other Health Plans. This means, the amount paid under any other Health Plan or provider, plus whatever benefit is provided from this Plan, will not exceed one hundred percent (100%) of your incurred Customary Charge. However, in no event will this Plan pay more than what would have been payable if there were no other Health Plans or providers involved.

All medical/hospital, dental and prescription drug benefits covered under the Plan are subject to the coordination of benefits provisions described in this booklet. To implement coordination of benefits, you may be asked periodically to provide information to the Fund Office about other coverage you or your Dependents have. Failure to timely provide the requested information may result in a delay in paying claims on your behalf.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability and implementation of the terms of this provision of this Plan or any provision of similar purpose of any other Health Plan, this Plan may (without the consent of or notice to any person) release to or obtain from any insurance company or other organization or person any information with respect to any person that the Fund considers to be necessary for those purposes. Any person claiming benefits under this Plan must furnish to the Fund any information that may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Health Plan, the Fund will have the right, exercisable alone and in its sole discretion, to pay over to any organization making the other payments any amounts that it may determine to be warranted, in order to satisfy the intent of this provision. Amounts so paid will be considered to be benefits paid under this Plan and to the extent of those payments the Fund will be fully discharged from liability under this Plan.

Right of Recovery

If the Fund pays benefits in error, such as when the Fund erroneously pays a claim that is not covered under the Plan, or if the Fund advances benefits that you or your Dependent are required to reimburse because, for example, you have received a third party recovery (see the "Subrogation and Reimbursement" Section of this SPD), you are required to reimburse the Fund in full and the Fund shall be entitled to recover any such benefits.

The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your Dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your Dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund provide the benefits available under the Plan and you comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Plan, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your Dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods, which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you, or on your behalf and any of your Dependents. If the overpayment or advancement was made to or on behalf of your Dependent, the Fund may offset the future benefits payable by the Fund to you and any of your Dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid or on whose behalf they were paid. If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed to the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit to enforce the provisions of this Plan in any state or federal court that has jurisdiction over the Fund's claim.

Fraud

The Board reserves the right to cancel or rescind Fund coverage for any Participant or Dependent who engages in fraud or intentional misrepresentation. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in Dependent status or accepting benefits in excess of what is covered under the Plan, will be considered fraud. In any case of fraud or intentional misrepresentation, the Fund will seek reimbursement for of retroactive benefits and may elect to pursue the matter by pressing criminal charges, to the extent permitted by law.

COORDINATION OF BENEFITS WITH MEDICARE

Active Participants Age 65 and Over and Their Dependents

If you work for a Contributing Employer with fewer than twenty (20) Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, and the Fund has obtained an exception from Centers for Medicare and Medicaid Services for your Employer, then Medicare shall be primary for you and your Dependents.

If you work for an employer with more than twenty (20) Employees for each working day in each of twenty (20) or more calendar weeks in the current or preceding calendar year, the following rules apply:

1. This Plan will be primary for any person age sixty-five (65) and older who is a Participant and for any spouse, age sixty-five (65) and older of a Participant of any age.

2. You or your Dependent may decline coverage under this Plan and elect Medicare as primary. In this instance, this Plan will not pay benefits secondary to Medicare for Medicare covered services. However, you will continue to be covered by this Plan as primary until you notify the Fund in writing that you wish to elect Medicare as primary, or unless your coverage under this Plan ceases.

Disabled Employees or Disabled Dependents Under 65

This Plan is primary for Participants or their Dependents who are under age sixty-five (65), and who are entitled to Medicare benefits due to Total Disability and who are covered under the Plan (other than End Stage Renal Disease).

End Stage Renal Disease

This Plan will remain primary for End Stage Renal Disease for the thirty (30) months of your entitlement to Medicare due to End Stage Renal Disease, to the extent required by law. Please consult the Fund for a more detailed explanation if this may apply to you.

SUBROGATION AND REIMBURSEMENT

Were you or your eligible Dependent injured in a car accident or other accident for which someone else may be responsible? If so, that person (or his/her insurance) may be liable for paying your (or your eligible Dependent's) medical expenses. These expenses are not covered under the Plan.

Waiting for a third party to pay for these injuries may be difficult. Since recovery from a third party can take a long time (you may have to go to court) and your creditors may not wait patiently, as a service to you, the Fund will advance your (or your Dependent's) benefits based on the requirement that you reimburse the Fund in full from any recovery you or your eligible Dependent(s) receive, no matter how such recovery is characterized. This means that you must reimburse the Fund in full if you obtain any recovery from any source, person or entity. This reimbursement and subrogation program is a service to you and your Dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays the costs incurred as a result of your or your Dependent's injuries.

You and/or your Dependent are required to notify the Fund within ten (10) days of any accident or Injury for which someone else may be liable. Further, the Fund must be notified within ten (10) days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims.

If you or your Dependent receive any benefit payments from the Fund for any Injury or Sickness, and you or your Dependent recover any amount from any third party or parties in connection with that Injury or Sickness, you or your Dependent must reimburse the Fund from that recovery, the total amount of all benefit payments the Fund made or will make in the future on your or your Dependent's behalf in connection with such Injury or Sickness.

Also, if you or your Dependent receive any benefit payments from the Fund for any Injury or Sickness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery that has accrued, may

accrue or which is asserted in connection with such Injury or Sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Sickness in your or your Dependent's name and also has a right to intervene in any action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether you and/or your Dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the Injury and Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. This includes amounts payable under your or your Dependent's own uninsured motorist insurance, under insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's rights of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your Dependent in obtaining recovery.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your Dependent or a representative of you or your Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your Dependent for the benefit of the Fund until paid to the Fund. You and your Dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your Dependent agree to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this section, if you or your Dependent submit claims for or receive any benefit payments from the Fund for an Injury or Sickness that may give rise to any claim against any third party, you and/or your Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement also must be executed by your or your Dependent's attorney, if applicable. However, even if you or your Dependent or a representative of you or your Dependent (including your or your Dependent's attorney) do not execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your Dependent, you or your Dependent's acceptance of such benefits shall constitute your or your Dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your Dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your Dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor

of the Fund on any payment amount or recovery that you or your Dependent recovers from a third party.

Any refusal by you or your Dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery your receive, no matter how characterized, up to the full amount paid by the Fund on your or your Dependent's behalf relating to the applicable Injury or Sickness, will be considered a breach of the agreement between the Fund and you that the Fund provide the benefits available under the Plan and you comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your Dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Plan, including but not limited to, a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your Dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your Dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your Dependent or your attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, are excluded from Plan coverage, as provided in this Section.

Under this provision, you and/or your Dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your Dependent's receipt of any recovery. If you are asked to do so, you must contact the Fund Office immediately. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent chooses not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your Dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your Dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your Dependent waives any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your Dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your Dependents' future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation Agreement and the failure of any party, including your attorney, to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your Dependent to obtain repayment of the benefits advanced by the Fund, you or your Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

Participants and/or Dependents are prohibited from assigning their ERISA rights to providers, with the exception that Participants and/or Dependents may assign the right to receive payment from the Fund to the provider for services rendered by the provider.

CLAIMS REVIEW AND APPEAL PROCEDURE

The following claims and appeals information applies to all of your uninsured medical, dental, prescription drug, and vision benefits. For your insured benefits, Life, AD&D, and Short-term Disability, please refer to the booklets issued by the insurer for details on the applicable claims and appeals procedures.

HOW DO I FILE A CLAIM FOR BENEFITS?

A claim shall be initiated by the filing of a completed and signed Claim Form. A Participant may obtain the necessary forms for filing a claim by telephone or writing to the Fund Office at 585 Stewart Ave. Suite 330, Garden City, NY 11530. The Fund will provide a Claim Form to custodial parents of children enrolled in the Fund pursuant to a Qualified Medical Child Support Order if the custodial parent is not a Participant. The claim will be processed as quickly as practicable and within the timeframes required by law; if additional information is required, the claimant will be notified and requested to furnish the necessary data.

HOW DO I COMPLETE THE CLAIMS FORMS?

Fully complete the patient information section of the claim form. Be sure to include your Social Security Number on the Claim Form. Also be sure to include your spouse's date of birth. Custodial parents submitting claims pursuant to Qualified Medical Child Support Order should include their own date of birth. Be sure to sign the Claim Form on the line specified. Have your

doctor or provider of medical service complete the back portion of the Claim Form. Claim Forms with missing information may delay processing and payment. Your phone number and area code are important because the Fund can resolve many details with you promptly on the telephone.

To assure prompt, accurate action on your claim, be sure that the Claim Form and the original, itemized bills are complete. They should contain all necessary information such as the name of the patient, the diagnoses, dates and descriptions of services, and itemized charges.

You may name a representative to act on your behalf during the entire claims procedure. To do so, you must notify the Fund in writing of the representative's name, address, and telephone number and authorize the Fund to release information (which may include medical information) to your representative. The Fund may establish procedures for determining whether the individual has been authorized. Please contact the Fund's office for a form. The Fund will then send all information regarding your claim to your representative.

WHERE DO I SUBMIT MY CLAIM FORM?

Where you file your claims will depend on the type of claim, as described below.

For all Pre-service medical claims you should call American Health Holding at 1-866-457-9882. For Pre-service dental claims (those claims for dental services in excess of $300), you should contact D.D. Services, Inc. at 1-516-794-7700.

For Pre-service vision claims and all other medical claims, you should file your signed claim form, including all itemized bills or required documents, with the Fund at 585 Stewart Ave. Suite 330, Garden City, NY 11530

WHAT ARE THE TIME LIMITS FOR COMPLETING AND FILING MY CLAIM FORMS?

Claims must be filed within one year after the claim has been incurred. Claims submitted after one year will be denied unless it is determined that there is a satisfactory explanation for the delay.

HOW LONG WILL IT TAKE FOR A CLAIM TO BE DECIDED?

The Fund's procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the Fund may also request that you voluntarily extend the period of time for the Fund to make a decision on your claim or your appeal.

Urgent Claim

An urgent claim is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a

Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. An urgent claim will be decided as soon as reasonably possible given the medical exigencies but no later than 72 hours after claim is received. If additional information is required, you or your representative will be notified within 24 hours of receipt of the claim and given not less than 48 hours to respond.

Pre-service Claim

A Pre-service claim is one that requires pre-approval under the terms of the plan. The requirements for pre-authorization or pre-approval are described on page 2 of your SPD. Your Pre-service claims will be decided within 15 days of receipt by the Fund. If it is determined that an extension of this time is necessary, the claim will be decided within 30 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 15 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If your claim is filed improperly, you will be notified of the problem within five days of filing the claim. If you do not provide the information requested, or do not properly re-file the claim, the Fund will have to decide the claim based on the information it has, and your claim may be denied.

Post-service Claim

A Post-service claim is any other type of claim under the Plan, such as a payment for covered services after a doctor visit. You will be notified if your claim is denied within 30 days after receipt of the claim. If it is determined that an extension of this time is necessary to decide the claim, the claim will be decided within 45 days of receipt (unless the period is extended while the Fund awaits receipt of information requested from you). You will be notified of the need for an extension within 30 days of receipt of the claim and the reasons why the extension is needed.

If the Fund needs more information from you to process the claim, you will have 45 days to provide the needed information to the Fund. If you do not provide the information requested, the Fund will have to decide the claim on the information it has, and your claim may be denied.

Concurrent Care Claim

A Concurrent Care claim is a claim that the Fund is asked to approve, or has already approved for an ongoing course of treatment or a certain number of treatments over time. If the Fund determines that treatment is no longer necessary you will be notified of the denial within a sufficient amount of time to allow an appeal before the Fund ceases or reduces coverage for your treatment. If you ask that Concurrent Care treatment be extended beyond the initially determined time, your claim will be decided no later than 24 hours after your claim is received by the Fund (if you make the claim at least 24 hours before the period or number of treatments expires).

HOW IS A DECISION REGARDING MY CLAIM MADE?

The Board of Trustees, in making decisions regarding claims, including appeals, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and ensure that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the Fund and Trustees will take into account all information you submit in making decisions on claims and on appeal.

The Fund, at its own expense, has the right to have a Physician examine you or your Dependent as often as is reasonably required while a claim is pending. The Fund also has and the right to have an autopsy performed at its own expense, where not prohibited by law.

If the Fund has all of the information needed to process the claim, it will be processed. If your claim was a Pre-service claim, you will receive notice regarding payment of your claim.

WHO WILL RECEIVE THE CLAIM PAYMENT?

If the Fund has all of the information needed to process the claim, it will be paid and you will receive a notice on an Explanation of Benefits form.

If you wish to have payment of a claim made directly to a service provider, you must authorize this on the claim form and the bill must indicate that payment has not been made.

Otherwise, payment of a claim is made directly to you, unless it is for a death benefit. If you die before all claims have been paid, if you fail to provide a forwarding address, or if you are deemed to be incompetent, the Board of Trustees will make payment to your named beneficiary or to your estate if you do not have a named beneficiary. If a beneficiary is a minor, or is otherwise incapable of giving a valid release for any payment due him, the Plan Administrator, until a claim is timely made by the duly appointed guardian, committee, or other legally authorized representative of such beneficiary, may make payments of the proceeds otherwise payable to such beneficiary to any spouse or relative of the beneficiary, or to any other person or institution appearing to the Plan Administrator to have assumed custody and principal support of that beneficiary.

WHAT NOTICE WILL I RECEIVE IF MY CLAIM IS DENIED?

You will be provided with a written notice of any denial of a claim (whether denied in whole or in part), which will include the following information:

- The claim involved (including the date of service, the provider involved, if applicable, and the claim amount);
- The claimant’s right to request diagnostic and treatment codes and an explanation of their meaning;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- if the denial of your claim was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- a description of any additional material or information necessary to support the claim, and an explanation of why the material or information is necessary;
- a description of the appeal procedures (including voluntary appeals, if any) and external review process and applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review and any related statute of limitations or forum selection requirements;
- for Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims (keep in mind that for Urgent Care Claims, you may first be notified over the phone or in person, with written notification to follow).

As part of the Fund's internal claims and appeals review process, you have the right to review your claim file and to present evidence and testimony in support of your claim and appeal. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the Fund, the Board of Trustees, or the Fund's other applicable claims-processing entities.

WHAT STEPS MUST I TAKE TO APPEAL A DECISION TO DENY BENEFITS?

Pre-Service Claims

Before you appeal to the Board of Trustees, you may wish to contact American Health with any questions or concerns you have regarding your Pre-Service medical claim denial. If you choose to do so, please contact American Health Holding directly at 1-866-457-9882 for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to American Health Holding, you have the right to appeal a benefit denial to the Board of Trustees within one hundred eighty (180) days of the denial of your benefit, as described above. However, if you choose to address your concerns to American Health Holding, you must do so before you appeal to the Board of Trustees and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of Trustees, you must appeal to the Board of Trustees within one hundred eighty (180) days of the denial of your benefit. If you have addressed your concern to American Health Holding, but have not obtained a response before the end of one hundred eighty (180) days from the denial of your benefit, you must file an appeal with the Board of Trustees before the end of that one hundred eighty (180) day period to preserve your right to appeal. If you file an appeal before you receive

a response from American Health Holding, you may ask the Board of Trustees to defer a decision on your appeal until you receive a response from American Health Holding; after you receive a response from American Health Holding, you must then notify the Trustees as soon as possible whether you wish to proceed with the appeal.

Other Claims

If your benefits are denied, in whole or in part, and you wish to appeal the Fund's decision, you (or your representative) should request that the Board of Trustees review your benefit denial by submitting a written appeal to the Trustees. The Trustees will review your appeal.

Your written appeal should state the reason for your appeal. You may submit written comments, documents, records, and other information relating to the claim. If you choose to appeal, upon request you can receive, free of charge, access to and copies of all documents, records and other information relevant to your claim.

Your appeal should be sent to:

Board of Trustees
Building Trades Welfare Benefit Fund
c/o Dickinson Group, LLC.
585 Stewart Ave. Suite 330
Garden City, NY 11530

WHEN MUST I SUBMIT MY APPEAL?

You have 180 days from the day you received notice of the initial decision to appeal your claims.

WHEN WILL A DECISION REGARDING MY APPEAL BE MADE?

Once your appeal is received by the Trustees, the time to issue a decision will depend on the type of claim and may be extended to the extent permitted by applicable law.

Urgent Claims

Appeals of urgent claims will be decided as soon as possible upon receipt, but in no later than 72 hours after the appeal is received.

Pre-service Claims

Appeals of Pre-service claims will be decided within 30 days after the Trustees receive the appeal.

Post-service Claims

If the Board of Trustees is holding regularly scheduled meetings at least quarterly, appeals of Post-service claims will be decided at the next quarterly meeting of the Trustees (or a designated committee of Trustees) immediately following the receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish

to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review by the Trustees, you will receive a decision no later than the third quarterly meeting, and you will be notified in writing of the need for the extension, why the extension is needed, and when a decision is expected. The Trustees will send you notice of this decision within 5 days of the decision.

If the Board of Trustees is holding regularly scheduled meetings less often than quarterly or otherwise in the discretion of the Board, appeals of post-service claims will be decided within a reasonable time but in no event will you be notified of the determination later than 60 days after receipt of the appeal.

Concurrent Care Claims

Appeals of Concurrent Care claims are governed by the provisions above for Pre-service or Post-service claims, whichever applies to the particular claim.

WHAT HAPPENS IF MY CLAIM IS DENIED ON APPEAL?

If your claim is denied on appeal, you will receive a written explanation that describes:

- The claim involved (including the date of service, the provider, if applicable, and the claim amount);
- The claimant's right to request diagnostic and treatment codes and an explanation of their meaning (such a request will not be considered a request for external review);
- The specific reason or reasons for denial, including the standards used and a discussion of the decision;
- Reference to specific Plan provisions on which the denial is based;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- If the denial of your appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement of your right to seek external review and to bring a civil action under Section 502(a) of ERISA following a denial of your appeal, including any applicable statute of limitations and forum selection requirements.

If the initial decision on a medical claim was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination or a subordinate of such person. In reviewing a denied medical claim, the Trustees will not automatically presume that the initial decision was correct. Rather, the medical claim will be reviewed with no reliance on the record used in making the initial benefit determination, and, by a named fiduciary of the plan who did not make the determination you are appealing and who is not a subordinate of any individual who made the determination that you now appeal.

If you wish to file lawsuit regarding the denial of a claim of benefits, you must do so within three (3) years of the date the Trustees denied your appeal. For all other actions against the Fund or Trustees, you must file a lawsuit within three (3) years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, any lawsuit against the Fund or the Trustees must be filed in either the Eastern District or Southern District Courts in the State of New York. These rules apply to all claimants, including you, your spouse, your Dependents, and any provider who provided services under the Plan. This Section applies to all litigation against the Fund and Trustees, including litigation in which the Fund is named as a third party defendant.

External Review of Denied Claims

If your claim for benefits has been denied and if you have exhausted the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization ("IRO"). External review is limited to claims involving medical judgment (e.g., lack of Medical Necessity, or a determination that a claim is Experimental or cosmetic), claims for Surprise Services, or a rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal). Requests for external review are filed with the Fund office.

<u>Preliminary Review</u>. Within five business days of receiving your request for an external review, the Fund will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the Fund's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except to the extent required by law, that preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

<u>Referral to Independent Review Organization</u> ("IRO"). If your external review request is complete and your claim is eligible for external review, your claim will be forwarded to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the Fund. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund, decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- A general description of the claim and the reason for the external review request
- The date the IRO received the external review assignment and the date of its decision
- Reference to the evidence considered in reaching its decision
- A discussion of the principal reason(s) for its decision, any evidence-based standards that were relied on in making its decision
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law
- A statement that judicial review may be available to you; and
- Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

<u>*Reversal of the Fund's decision*</u>. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

Expedited External Review of Denied Claims

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an

appeal is submitted.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision on as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

OTHER IMPORTANT INFORMATION

The Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan.

The decision of the Board of Trustees is final and binding. However, you have the right to file a suit in federal or state court under the Employee Retirement Income Security Act on your claim for benefits, provided that you had filed an appeal pursuant to the Fund's appeal procedures described above and your appeal has been denied.

New York Surcharge

New York State law has many rules regarding how health care is financed in New York State. One of these rules is that there is a surcharge (an additional amount added to the usual charge) to Expenses for services provided by any of the following facilities located in New York State: Hospitals, both in-patient and out-patient (including emergency room), diagnostic and treatment centers, and ambulatory surgical centers. This surcharge changes from year to year. It is the responsibility of the Plan to pay the surcharge on any portion of the charges that are paid for by the Plan. This surcharge will be considered a paid claim. The surcharge will be considered a paid claim for subrogation and overpayment purposes under the Plan as well. It is the Participant's and/or the Dependent(s)'s responsibility to pay the surcharge to the provider on any amounts that are not paid for by the Plan.

In addition to the Expense surcharge, there is a monthly surcharge that the Plan must pay directly to the State of New York for each Participant and/or Dependent(s) residing there. This surcharge varies based on individual or family coverage and the geographic region in which the Participant and/or Dependent(s) live.

ERISA RIGHTS AND INFORMATION

As a Participant in the Building Trades Welfare Benefit Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participant shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the Fund's office and at other specified locations, such

as worksites and union halls all documents governing the Plan including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description, and other Plan information upon written request to the Fund. The Fund may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Fund is required by law to furnish each Participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Procedure for Obtaining a HIPAA Certificate of Creditable Coverage

The Fund will send a Certificate of Creditable Coverage to you and your Dependents that shows how much coverage you have had under the Fund within a reasonable time after you lost coverage under the Fund for any reason, or if you would lose coverage under the Fund if you had not elected COBRA coverage. You do not need to make a request to get a Certificate if you lost coverage or would lose coverage. In addition, you or your Dependents may request a Certificate of Creditable Coverage at any time while you are covered under the Fund and up to two years after you lose coverage under the Fund by writing to:

Building Trades Welfare Benefits Fund
585 Stewart Avenue, Suite 330
Garden City, NY 11530
516-833-9300

If you request a Certificate, the Fund will send it within a reasonable and prompt period of time.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Dependents.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Fund to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Fund, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

GENERAL PLAN INFORMATION

Eligibility and Benefits

The Plan’s requirements pertaining to eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are set forth in the preceding pages of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss forfeiture or suspension of any benefits are contained in the preceding pages of this booklet. Please also refer to the booklets for your Life and AD&D and Short-Term Disability benefits for additional information regarding circumstances which may affect your benefits.

Sources of Plan Contributions

Contributions to the Fund are made to a qualified tax-exempt Trust Fund. Sources of contributions to the Fund are contributions made by participating employers pursuant to collective bargaining agreements or other written agreements, except that retiree benefits are provided on a self-pay basis. The method of calculating contributions is outlined in the applicable collective bargaining agreements. These monies are reserved irrevocably for payments on behalf of Plan Participants and for administrative Expenses. The funds cannot be used for any other purpose and cannot be withdrawn by either the Contributing Employers or the Union. The financial activities of the Trust Fund are audited annually by a Certified Public Accountant.

In no event shall any assets of the Fund revert to any Employer. In the event of termination of the Plan, the allocation and disposition of plan assets will be in accordance with the Board of Trustees' determination.

Medium for Providing Benefits

This Plan was established and is maintained in accordance with collective bargaining agreements or participation agreements of Contributing Employers. Upon written request to the Fund Office, Participants and Dependents may obtain copies of the collective bargaining agreements, and copies are also available for examination by Participants and Dependents at the Fund Office.

Your medical, dental, prescription drug and vision benefits are provided directly through the Fund. The Fund has entered into contracts with the Hartford Life Insurance Company for your Life and Accidental Death and Dismemberment benefits and for your Short-term Disability benefits. These benefits are fully insured and paid pursuant to the respective insurance contract and the insurance company provides claims processing services for these benefits. The address for the Hartford Life Insurance Company is listed below:

Hartford Life Insurance Company
200 Hopmeadow Street
Simsbury, CT 06089

IMPORTANT SUMMARY PLAN INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Name of Plan

The name of the Plan is the "Building Trades Welfare Benefit Fund".

Plan Sponsor

The name and address of the Plan Sponsor is:

Building Industry Electrical Contractors Association
1150 Portion Road Suite 19
Holtsville NY, 11742

Trustees

The names and addresses of the Trustees of the Plan are:

Frank Rappo
c/o Building Trades Welfare Benefit Fund
585 Stewart Avenue, Suite 330
Garden City, NY 11530

Eric Olynik
c/o Building Trades Welfare Benefit Fund
585 Stewart Avenue, Suite 330
Garden City, NY 11530

Counsel
Slevin & Hart, P.C.
1625 Massachusetts Avenue, N.W., Suite 450
Washington, D.C. 20036

Administrative Manager
Dickinson Group, LLC
585 Stewart Avenue, Suite 330
Garden City, NY 11530

Auditor
Calibre CPA Group, PLLC
462 Seventh Avenue, 16th Floor
New York, NY 10028

Employer Identification Number and Plan Number

The Employee Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 11-3310062. The Plan Number the Board of Trustees has assigned to the Plan is 001.

Type of Plan

The Plan is a group health plan under the Employee Retirement Income Security Act of 1974

(ERISA). It provides life insurance, disability, accident, hospital, surgery, medical, laboratory and x-ray, dental, and vision benefits, home health care, major medical, mental/nervous emotional disorder, alcohol/substance abuse and prescription drug benefits described in this Summary Plan Description.

Type of Administration

The Plan is administered by the Board of Trustees of the Building Trades Welfare Benefit Fund.

Agent for Service of Legal Process

The Agent for service of legal process is:

The Trustees of the Building Trades Welfare Benefit Fund
585 Stewart Avenue, Suite 330
Garden City, NY 11530

Service of legal process also may be made on a Plan Trustee.

The Plan Year

For purposes of maintaining the Plan's records, the Plan year begins January 1 and ends December 31 of each year.

The Plan Website

https://www.btwelfarefund.org/

Benefits and Rules Changes

It is intended that this Plan will be maintained indefinitely. However, the Trustees may at any time modify or reduce any benefit coverage or change any rule or regulation, in order to protect the financial soundness of the Plan or to better serve the Participants. Any changes made will be uniformly applied to all Participants. In addition, the Contributing Employers may amend or terminate this Plan and the Fund at any time if and to the extent provided in the agreements between them.

The Trustees shall have the sole power and discretion to construe the provisions of the Plan and the terms used herein. Any construction adopted by the Trustees in good faith shall be binding on the Union, the Contributing Employers and all Plan Participants.